FAMILY PLANNING IN INDIA: POLICY AND ADMINISTRATION

FAMILY PLANNING IN INDIA

POLICY AND ADMINISTRATION

(Proceedings of Three Seminars)

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THIRD SEMINAR

FOREWORD

It was in 1951 that family planning was launched formally and officially as a Government of India programme. Many people then thought that it was unnecessary; some were struck by its novelty. Yet, even though the programme has been going on for over two decades now, it has not produced the impact that it was expected to. The Central Ministry of Health and Family Planning which administers this programme wisely thought of throwing the subject open to intelligent and enlightened public discussion with a view to identifying the problems in their contemporary context and sorting out their own ideas in regard not only to the measures to be adopted for successful implementation but also—and this was particularly heartening—to find out the reaction of knowledgeable people to the *raison d'etre* of the policy itself. Hence the seminars on Family Planning—Policy and Administration, for which the Ministry provided full financial support. The Indian Institute of Public Administration, on its part, was itself interested in the administrative problems of this very important programme with ramifications at the State and local levels, including voluntary organisations. In order to ensure extensive participation, three seminars were held with different participants on each occasion, drawn from the academic, professional, administrative and political fields as well as from voluntary organisations.

People the world over have talked about 'population explosion' and much caution has been administered to countries—mostly the developing ones—with a rather fast rate of growth. It is in the wake of these warnings that a realisation of the seriousness of the matter has come about. Yet, population has to be looked at as one facet—though very significant—of the total picture. Even here the density of population, rather than the magnitude of the total population, is perhaps a better indicator. As far as India is concerned, even though, in absolute numbers, it occupies the second position in the world, in the matter of density, it comes below a number of developed countries. For instance, according to the UN Statistical Year Book, whereas the density of population in India was 164 per square kilometer in 1969, in Japan the comparable figure was 277, in Belgium 316, in U.K. 228, in West Germany 237 and in the Netherlands 315. The re ference to these figures is not to suggest that Family Planning as a governmental programme is a waste of time. Its urgent and insistent necessity, no one can deny. The emphasis laid upon it by the Central Government and the efforts made to achieve success deserve every commendation. But policies and programmes have to be thought out carefully, particularly for societies with deep orthodoxies and abiding reverence for tradition. Above

all, very detailed attention has to be given to the manner of implementation. Decisions cannot be taken in a panic; nor should they be lightly reversed because of passing set-backs.

We in the Institute feel happy at the outcome of the seminars : the discussions were illuminating and stimulating; the coverage was comprehensive and revealed large areas of agreement in regard to principles. But, as was to be expected, there was difference of opinion in regard to details, particularly in the matter of implementation. The view that programmes should emerge rather from *family welfare* policy than mere *family planning* found several outspoken exponents.

The proceedings of these seminars are now being presented to the public in this volume, and I have no hesitation in saying that the papers and the discussions cover practically all the issues of policy and administration concerning Family Planning. The volume will be of great interest not only to the concerned administrators, but also to social scientists, demographers and others.

I must take this opportunity of thanking the Ministry of Health and Family Planning for their generous assistance to the Institute for holding these seminars. Prof. V. Jagannadham, as Director of the seminars, had to shoulder all the responsibility of having the necessary papers prepared for the seminars and conducting them, and the Institute is deeply indebted to him, as well as to the late Prof. B. S. Narula for his assistance. Needless to say, the Institute is very grateful to all the participants whose ready co-operation contributed so much to the success of the seminars. Mr. R. N. Madhok, Additional Secretary and Mr. Pratap Kapur, Ministry of Health & Family Planning deserve our thanks for helping us with the arrangements, besides participating in the discussions.

G. MUKHARJI
Director
INDIAN INSTITUTE OF PUBLIC ADMINISTRATION

NEW DELHI
JANUARY 3, 1973

INTRODUCTION

Anything about India is frightening because of the increase in the number of people from decade to decade. The fright is heightened by the comedy of contradictions. Humanism which characterizes the climax of cultural progress compels us to think of controlling fertility so as to make it proportionate to reductions in mortality. The latter is made possible by advances in knowledge about diseases, medicine and drugs. Consequently, to nip in the bud the increase in human numbers, much investment is suggested in contraception and abortion under State auspices. Many argue against State campaigns of mass sterilization. Camps are criticised as an infringement of individual freedom in the most intimate and inner-most aspects of personal and domestic life. Besides being an infraction of freedom, some doubt whether a small family is a happy family in the face of spiralling prices, ceiling on wealth and falling productivity. A feeling prevails that family planning i. a facile suggestion of foreign economists of the developed countries to those in the developing countries; it is also described as an alibi of the ruling parties for the failures of their policies, plans and programmes in respect of greater production and more equitable distribution of wealth and opportunities. All these rumblings among intellectuals deserve consideration by the policy makers.

The "population explosion", as it has come to be called in consonance with other explosions such as urban explosion, knowledge explosion, etc., is not local to India but global in character. Many demographers estimate that by the first quarter of the twenty-first century, the food supplies will fall short of the increasing number of mouths. This is an astounding observation because "green revolution" and "white revolution" and revolution in synthetic preparation or production of food should, in an age of limitless technological innovations, enable us to feed the whole of mankind, whatever its size may be.

Two constraints, however, impede a realisation of this. Firstly, human beings do not easily take to synthesized food notwithstanding their hygienic preparation and nutritious value. Convivial traditions die hard among people, however developed a nation's resources may be. Secondly, the sovereign nation states do not seem to realise that they have outlived their usefulness and the trade barriers among these states do not permit an easy flow of goods to the needy people in different parts of the globe.

Apart from the global macro issues, the adjustment of the balance between human and natural resources from the standpoint of desired standards of living is enveloped with foggy ideas and feeble efforts.

For example, the norms about standards of living suffer from "cultural" claptrap. Take the case of a state where wealth is plenty and people are few. Its per capita income may be among the highest but none would call it a developed country if it is low in such services as education, health, recreation, housing, etc., whose presence or absence indicates the abstract standards of life

On the other hand, India is below normal in many respects—whether concrete or abstract, wealth, goods, literacy, health, etc. But very few would say that it is culturally below "normal". The standard setting has become a function of measurable rather than intangible indices of culture.

The family planning policy has been closely associated with the phenomenon of the nation's poverty and its mitigation, if not abolition. Poverty again is viewed in abstract in aggregate terms, namely, G.N.P., per capita income, etc. While these are sound indicators for planners, these make no sense to individuals and families. The appeal to the latter to limit their families so as to increase per capita income falls on deaf ears. Further, to say that a small family means a happy family also does not click because of the high rate of infant mortality, risky adult life, eagerness for a couple of surviving sons, lack of security in old age, and the contribution to earnings by the children. In other words, the citizens' minds are influenced by personal gains or losses, whereas the policy makers and administrators refer to national goals and country's wealth. Individual citizens and state policy makers are not articulating on the same wavelength even about poverty. The interests of both do not seem to coincide very much. To build and promote a consensus *ad idem* between the individual and societal goals is the prime requisite of a family planning policy.

Moreover, the whole approach to the mitigation/abolition syndrome of poverty is oriented to the traditional philosophy of development by investment on hardware and infrastructure. But the mass of the people, accustomed to abysmal poverty, resignation and fatalism, cannot awaken themselves to hard labour and savings for investment in the absence of health, skills and opportunities for employment. The traditional value of abnegation and the traditional virtue associated with poverty operate as hurdles to rouse the consciousness of the people. If we juxtapose the lack of opportunities for gainful employment to the traditional outlook towards enhancing prosperity and multiplication of wants, we would appreciate the gulf that separates knowledge from acceptance and these two from practice in family planning. Within this framework, we could also appreciate the hesitation of political parties to commit themselves to an enthusiastic enunciation of family planning policy in the election manifestoes. To counteract the cultural attitudes and behaviour hostile to small family norms is the major task and the prevailing systems of communication and community action cannot tackle this work. These matters also need further review.

Where political parties hesitate, administrators sometimes take the initiative and formulate programmes which, in their view, are beneficial to the country. Family planning pronouncements first appeared in the Five Year Plan documents and were endorsed by political leaders in Government. Allocations and programmes followed suit. All this happened at the Central Government level. During the last two decades, much money was spent and many approaches have been tried by the Government of India in the field of family planning as a cent per cent centrally financed scheme administered by Central, State, and local governments as well as non-Governmental institutions under grants from the Central Government. Family planning programmes are, by and large, initiated and experimented upon by the administration though they have the blessings of ministers. But they do not have the coherence of a comprehensive policy nor the mandate of political parties or the electorate. This aspect deserves the closest attention of the Government.

It will be observed from the papers and discussions in the Seminars, how the lack of political commitment and electorate support is a drawback in the implementation of family planning. The administration relies more upon monetary incentives than on the community's acceptance of small family norms. The incentive approach is reinforced by campaigns by the officialdom probably by coopting some non-governmental institutions on the way.

No exception need be taken to these developments in administrative initiatives blessed by political executives. This cannot, however, be an all-time arrangement. A departmental activity should be converted into a national movement. How to do this ? The policy aspect assumes significance in this light. The central, state and local deliberative bodies, elected, as they are, by the same voters, should have the courage to discuss the programme in the deliberative bodies and through their constituents. Many critics suspect that the political parties are themselves not convinced about the commitment to the family planning programme. Therefore, they say that the parties have considered it expedient to leave initiative to the department of the central government. Even the incentives and investments have to be provided by the department. Family planning policies consequently flow from a distant Government department in Delhi and hence do not fuse into a movement at different levels of individual, family and community life.

If we concede this diagnosis as correct, there is a serious danger of investment in planning, yielding feeble returns. What India needs to achieve rapid development is not a mere socio-economic change but a societal revolution. Events are moving in that direction through industrialization and urbanization. If these are to be directed, instead of allowing them to drift,—as confessedly it is the purpose of planning to direct the change,—the family planning programme must be lifted from a mere departmental

activity to a national movement. What are the implications of this statement ? Readily two of them could be mentioned.

1. *Popular Acceptance of Small Family Norm*

The small family norm is of revolutionary import. Extended or joint family and clannish kin groups are the normal units of social structure in India. The social value system is woven around them. Under compelling circumstances of spatial and social mobility, people tend to move away physically from these core units of interpersonal cohesion but the ethnic and psychic loyalties still manifest themselves in the form of monetary remittances and clannish loyalties at home in urban areas and abroad, wherever Indians settle outside the country. Nothing wrong is implied in mentioning these characteristics but in order to get the people out of the legacy of large family norms and clannish loyalties, and legitimize fulfilment in a small size family, a deliberate effort has to be made to get the whole metaphysical and social value system changed. For instance, in a small size family when the two or three children become of school going age and go to schools and colleges and to jobs outside the village, town or city or country, the parents find themselves condemned to loneliness, helplessness and frustration. So do the children at the other end. The parents have not grown up in a society like that of the west where the stress is on the individualistic personality cult. Links between generations are snapped and parents find themselves confronted with the problems of children conflicting with the pursuit of their activities without grand parents acting as educators or insulators. Institutional services such as baby sitting, creche, etc., have not become as yet common in India. No attempt is in evidence to tackle this problem in the family planning department.

2. *Social Security and Family Welfare Plan*

The second, namely, the need for a social security and family welfare plan, is a direct consequence of the first. Acceptance of and living according to, small family norms requires a comprehensive scheme of social security and family welfare planning. This has been brought out vividly in the papers and in the discussions during the seminars. Family planning administration will flounder as soon as the incentive schemes are modified adversely, if, simultaneously, adequate steps are not taken to introduce social services to ensure high rate of longevity and social security to take care of a minimum standard of living for the adults and the aged. A direct correlation could be established between assured economic security and propensity for reduced reproduction.

These two lines of approach become explicit if the family planning proposals are put to discussion by political parties in their constituencies, assemblies and councils. Democratic governments, whatever party may be in power, then will be induced to transform their development policies towards improving human as against hardware capital. In a democracy,

a departmental activity could be transformed into a national movement, provided the people's fears and aspirations are heard and responded to. Family planning in India is operated through bureaucratic initiatives and processes and this feature needs modification.

In policy matters, commitment of the political leaders and political parties is essential. On the other hand, in implementation, the chief requisites are programme designing and programme execution with an emphasis on assessment of effectiveness of implementation and a mechanism of feed back of information about outputs to those engaged in policy formulation and resource inputs. How far are these expectations fulfilled in the administration of the Family Planning Programme ? Some answers to these questions would be found in the papers contributed to the Seminar. Here a few general observations are given. Very few empirical studies are available on administration *per se.* Many review reports speak of administration and they contain some useful suggestions. Most of the suggestions pertain to personnel, procedures, communications, etc. These are indeed relevant but we hardly come across any attempts at dovetailing family planning into developmental administration.

So far many changes have been effected in the design of the family planning programme such as IUCD, Nirodh, Pills, Vasectomy and Tubectomy, etc. Starting from a major emphasis on IUCD in the fifties, we have reached the stage of a cafeteria approach. Under the latter, freedom is available to the individual to choose the method he or she likes. The cafeteria approach has recently been reinforced by campaign for sterilization. The pros and cons of the campaign and the organisation of the campaigns are also dealt with in detail by the papers and in the discussions. However, what is not clear is the relationship between shifts in emphasis on programmes and the objective or policy. Different methods of programme implementation are, at different periods, sprung upon the public by the administrators, probably endorsed by high level politicians such as those in charge of the planning programmes at central and state levels. There does not appear to be much discussion in public forums about the appropriateness of the methods in relation to the objective. Similarly, the incentive mechanism also has been undergoing modifications. In fact, sometime ago, some states introduced punishments under administrative decrees, such as withholding hospital bed facilities for a would-be mother for the fourth or subsequent confinement. Some suggestions have been made to withhold maternity leave benefit in similar cases. These were later either withdrawn or probably enforced informally. The reward and punishment approach towards popularisation of small family norm has probably been adopted with bona fide motives and good intentions by administrators but without proper discussions in the appropriate deliberative organs of government. There does not seem to be any qualms about the health of the mother or the unborn baby in the punishment scheme.

The punishment idea suggests the audacity of administration to introduce changes in matters that affect the habits and attitudes of citizens without consultation and concern for their welfare. Administrative supremacy is probably inherent in matters initiated by administration without the backing or basis of a statute as is the case with family planning. From the citizens' point of view, administrative manipulation of programme content without prior discussion by legislature is likely to endanger public morale and civic rights.

A second drawback in the administration of the family planning programme is its identification with the health department and with the medical—clinical aspects. Attention has been drawn to this drawback by several authorities. The non-clinical, and particularly, the social implications of the family planning programme have been emphasised in the Seminars. Attention also is drawn to the fact that the administration of the programme by a separate department within the Health Ministry does not seem to improve matters. There is need to evolve a mechanism wherein the several departments of a government, such as health, education, welfare, labour, social security, employment, etc., work together as a team in assisting policy formulation comprehensively and in implementation of the policy with mutual and reinforced cooperation of all. There is a suggestion that a separate statutory organisation like a Family Planning or Family Welfare Planning Corporation at the Centre with State branches would be a more satisfactory system. The advantages of such a separate corporation are, apart from enlisting the cooperation of different departments in government, also to be found in associating non-official leaders with the corporation. The task of the corporation would be to transform a programme into a movement. Such a step presupposes the formulation of a definite family planning policy and its enactment into a statute by the party in power and also of ensuring the cooperation of opposition parties with the implementation of the policy.

Family planning has revolutionary consequences for countries with hoary traditions like India. It implies a break-away from the traditional beliefs and behaviours. For putting across the message, the KAP tests hardly bring out the full role of mass media, audio-visual advertisements or subsidised sale of nirodhs. More important besides these is the need to instil personal confidence among people by demonstrated examples of neighbours or relatives. Creating such confidence becomes quantitatively and qualitatively different, if the means adopted are closely tied up with the familiar idioms and media of culture by the leaders of the community at the neighbourhood level. Probably different types of media and well known idioms of communication should be tried for different areas like the urban and the rural; and for communities at different levels of living and of varying degrees of social consciousness. Adaptation of more imaginative and subtle methods to suit different individuals and groups

seems to be still a desideratum.

Working in close collaboration, if not in partnership, with non-governmental organisations is being tried but in this as in other areas, the experience is not all very happy. The crux of the problem lies, according to me, in the lack of a comprehensive policy, a statutory base, and personnel trained thoroughly to put across the message and to administer the programme on a special footing. The administration's capacity to work with the people instead of for the people is deficient in many respects. In this, the role of non-officials and non-governmental organisations is inestimable but these have not yet been mobilised.

A circular process is vitiating the development thought and efforts. Without material prosperity, the rate of reproduction cannot be brought down. Population explosion is negativing the growth achievements in material prosperity. High fertility seems to have a direct correlation with low productivity rather than low capital investment. By effective investment on the development of people and their strength and skills there is a possibility of accelerating societal revolution and that would surely accelerate material growth. This has been the experience of many socialist countries. This realisation has been slowly dawning upon the minds of planners and policy makers. We may hope that, in future plans, we will be able to raise the productivity of people and thereby influence the propensity of the bulk of the people to reduce the reproduction rate. The goods and heads ratio no doubt needs alteration but the alteration is of revolutionary dimensions and it needs revolutionary means to succeed. It is not a matter of mere human arithmetic, but one of human attitudes and behaviour. The former only indicates and helps us to interpret but does not help us to change the latter. For that, we need innovative leadership, media and messages.

While the family planning policy and implementation have been receiving attention, the same cannot be said about integrating these into the national development planning. Let me hasten to clarify the statement. The need for investment on family planning finds adequate support and allocation in successive Five Year Plan documents. What the statement in the first sentence implies is that it is not woven into the fabric of the development plan as such. The concept of the development plan is still fragmentary and compartmental; and it is subject to the dictates of administrative departmental conveniences rather than to a mutually reinforcing system of priorities which will be supported by subsidiaries. Economic and social developments are conceived and operated upon separately; rather than as mutually supporting and supplementing sectors. For example, education is not related to employment and vice-versa. Cloth and food production do not bear any meaningful relationship to the needs and purchasing power of the bulk of the people. So does family planning programme stand by itself and is not integrated with health,

education, employment social security, social welfare, etc. This in brief is the consensus which emerged out of the discussions in the three Seminars. Unless the total development planning process undergoes a radical change towards an integrated social development plan, the fragmented family planning exercises would hardly succeed in achieving the goals in view.

The three Seminars were held consecutively in May, June and August, 1971. They were attended by a total of 105 participants, drawn from different fields of national life. We attempted to get more persons from varied sectors of public life to participate in the Seminars, but the constraints of weather, distance and individual convenience prevented our hopes from fuller materialization. Again, exigencies of time and pressure of work, both of individuals and of the Institute delayed the publication of the papers and the summaries of the discussions of the Seminars. Part of the delay was due to our waiting for receiving comments upon the draft resolution. The Ministers' speeches, the papers and the summary of the discussions are put together after some editing so that a wider and a different reading public may come to know about the concern and contribution of the Institute to a vital issue like the policy and administration of the family planning programme.

My grateful thanks are due to the Ministry and Ministers of the Central Government, to the participants, to the Director and the staff of the Institute, who helped me in successfully conducting the three Seminars. Posthumous though it is, I must thank the late Prof. B. S. Narula for taking charge of the second Seminar in June, 1971. Shri N. S. Bakshi, currently Under Secretary, Ministry of Health, F. P. Department (then the training associate in the Institute attached to me) has borne the brunt of the work associated with holding three national Seminars consecutively. My thanks are due to the painstaking effort put in by Shri K. Venkataraman for carefully going through the typescripts and editing them for publication. The Superintendent, Shri Ramakrishna, and the secretarial and typing staff of the office of the Training Division have, as usual, fulfilled the many demands made upon them without demur or delay. In particular, Shri Chandanlal, the typist attached to me, has, with his usual patience, calmness and smile, done an excellent job of typing and cutting the stencils. The valuable ideas in the papers and the discussions reflect the intellectual commitment and stimulus of the many participants who wish to see India's population reduced without damaging the culture and conscience of the millions of people that live in India. My task has been relatively easy and my personal contribution is fairly negligible. The book is now presented to the public in the hope that it will generate a greater awarness of the issues involved and lead to a real national movement of family planning.

V. JAGANNADHAM
Professor
INDIAN INSTITUTE OF PUBLIC ADMINISTRATION

NEW DELHI
JANUARY 3, 1973

FIRST SEMINAR

MAY 19—21, 1971

INAUGURAL ADDRESS

PROF. D. P. CHATTOPADHYAYA*

Mr. Chairman, Ladies and Gentlemen,

When the Indian Institute of Public Administration approached me for inaugurating this series of seminars, I had just taken over as Minister of State for Health and Family Planning. Normally, I should have hesitated to involve myself in a public function so soon after taking charge of a subject with which my acquaintance so far had been from a distance.

However, when I was told that this would be a meeting of academicians, I gladly accepted because I felt that I should be talking to people from a walk of life with which I have been familiar and with whom I could speak without inhibition.

I have agreed, therefore, to speak even though what I have to say at the moment can only be tentative. The first tentative conclusion at which I have arrived is that, in the programme of family planning, we have reached a stage where we need to take stock of our achievements and limitations, review our strategy and think of new ways to give the programme a greater push and drive in order to achieve our objectives.

I do not minimise the achievements. They have been very impressive, indeed. Nearly 8 million people have undergone sterilization. That number is equal to, or perhaps more than, the total sterilizations in the rest of the world.

Statistics in other fields such as conventional contraceptives also indicate an impressive record. Without going into detailed statistics, I think it will be safe to say that the family planning programme can justly claim to have made a contribution to the welfare of India. That is the fact which, I think, is undeniable.

At the same time, it is equally undeniable that the number of total acceptors of family planning is not rising at the rate at which it ought to be, if we have to bring down the birth rate to 25 per thousand within a reasonable period of time.

In order to speed up the implementation of the programme, we must always be willing to think of new directions and new ways. It is precisely for this purpose that the Department of Family Planning and the Indian Institute of Public Administration have joined hands to have a series of

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seminars where the intellectuals of the country could tell us what, they think, ought to be done in the field of family planning and population control.

The family planning programme, as a mass programme, began some time in 1966. A very wide awareness and an atmosphere of social acceptability has been created. Is it possible that we need new approaches both in the field of motivation and services, if we have to bridge the gap between the wide awareness and the relatively low level of acceptance ? At this stage, I can do no more than pose some issues for your consideration in the course of your deliberations.

Perhaps, the gap between awareness and acceptance is bound to be there in any programme that seeks behavioural change. Especially in a traditional society like that of India, such a programme takes time to find roots. The gap between awareness and acceptance and practice is, therefore, bound to take longer to fill in our country than in other societies.

However, that is a problem which we have to tackle. One of the questions that has been asked in the Ministry is whether the educational and motivational approaches that we had adopted at the start of the mass campaign were good enough only for that group of early innovators which exists in any population. Have we included, or at least placed sufficient emphasis on, those basic motivations which lead to the acceptance of the norm of a small family—motivations relating to the health and welfare of children and mothers ? Would it not be better, if family planning is presented as a part of the total development of a community ?

On the side of services also, we have been thinking that, perhaps, a greater integration of the family planning service with the health and care of women and children would yield greater results than a family planning service by itself. Some steps in this direction have already been taken but these, of course, cannot be considered adequate.

A third aspect to be considered is the relationship of the development of the norm of small family to the growth of educational level and the age of marriage, especially of women.

The family planning programme has never been isolationist in character, but, in the early stages of a crash programme, when the main purpose was to create widespread awareness and lay down the basic structure of the services, a certain amount of exclusiveness was, perhaps, inevitable and even useful for building the infrastructure.

My own view is that the norm of a small family can grow only as part of the process of modernisation in all directions. But, India's economic situation being what it is, we cannot wait for the process of modernisation to be completed in other directions before the ideal of a small family can be spread.

India is somewhat peculiarly placed compared with other countries in the matter of population growth. In the economically developed countries, development generally coincided with the period of increasing

population. Family planning and economic development were, in the main, unconnected. The Church, the State and the size of population were all unfavourable towards family planning, and yet these other countries did not encounter population explosion on the same dimension as we did because educated and enlightened married couples wanted smaller families. This is true not only of Protestant but also of Catholic countries.

India is placed in a somewhat different situation. We were faced with a rapidly increasing population even before we had built the infrastructure for sustained economic growth. In a vast and poor country like ours, economic development, family planning and national health are integrally related and, therefore, these cannot be left to individual motivation, particularly because of widespread illiteracy and traditional inhibition.

Even in socialist countries, where family planning is reported to be not officially encouraged, it is steadily gaining ground. In China, too, where family planning was initially frowned upon, it is being actively promoted.

The challenge has to be met. Various problems are bound to come up,—for instance, a belief, that family planning might upset population ratios resulting in disadvantage in political power and social influence. All these problems have to be overcome.

It should be, therefore, clear that a check in the growth of population has to be, in our country, one of the vehicles of modern economic development. That is why I said that we cannot wait for the total process of modernisation to be completed and for the movement towards the small family ideal to develop in the normal way.

But there is no doubt that the small family norm must be presented as part of the total development package in political, social and economic terms. I hope, therefore, that this seminar would help determine the manner and the method by which this can be achieved.

In the operation of a programme of such dimensions many management problems arise. One of the principal difficulties we have been facing is the shortage of medical staff in rural areas. There is a tendency on the part of professional people to shun the rural areas. Our Ministry has taken steps to give special incentives to attract doctors to the villages. But the demands of the rural areas for medical services are very great and extremely urgent. Unless we can give assurance of proper health care to the children that are born, the credibility of even the family planning programme may suffer.

Another serious problem is one of follow-up of those who come to us for sterilization or IUCD insertions or other clinical help. This, again, requires a well-knit and extensive medical and health care service. Even more, it requires a sense of dedication on the part of doctors.

Again, on the motivation side, we need to consider how best we can use the communication machinery that already exists for other development

purposes such as agricultural extension and community development.

These are some random thoughts which, I thought, I should place before you. I hope that you will, in your deliberations, find time to discuss, among other things, these few suggestions that I have placed before you.

Once again, I thank you for inviting me and giving me this opportunity to share what I call my tentative thoughts with eminent people who have come for this seminar. The fact that many of you have spared time from academic and other activities to participate in this seminar shows the interest that the Indian intellectuals have developed in family planning. This, I feel, is our greatest asset and the greatest assurance that this programme will succeed for the good of the common man both as an individual and as a member of a developing society.

WORKING PAPER

PROF. V. JAGANNADHAM*

SECTION I

A. *Aims and Objectives of the Seminar*

The Government of India has accorded a very high priority to family planning programmes in the Third and Fourth Five Year Plans. This is reflected in the organisation and finance which the Government has been providing for the programme. The increase in India's population from 365 million in 1951 to 445 million in 1961 and to 547 million in 1971 has been the result of a sharp decline in the mortality rate without any significant change in the fertility rate. There are about 21 million births and 8 million deaths a year adding 13-14 million to the existing population every year. It appears that at the current rate of increase in the population, we would have in this country an incredible population of more than 1 billion, before the end of the century.

This phenomenon has been primarily due to the birth rate remaining unchanged around 40-41 per thousand of the population during the last two decades in spite of the heavy investments in the family planning programmes. The Third Five Year Plan made a provision of Rs. 27 crores for this purpose though the actual expenditure was only Rs. 24.86 crores. In the Fourth Five Year Plan, a provision of Rs. 315 crores has been made for family planning programmes. Since April, 1966, a separate Department of Family Planning has also been constituted at the Centre with a view to coordinating family planning programmes at the Centre and in the States.

This seminar is aimed at discussing problems relating to policy formulation and administrative organisation in the field of family planning, both of which perhaps need revision so as to make the family planning programme more effective in its impact.

The major objectives of the Seminar are :

(*i*) to review the family planning policy of the Government and to suggest modifications therein with a view to achieving better results; and

(*ii*) to identify the social and administrative factors that affect adversely the proper implementation of the family planning programmes.

*Professor, Indian Institute of Public Administration, New Delhi.

B. *Scope of the Seminar*

The rapid growth of population has brought about tremendous problems particularly by rendering the investment on economic growth and development nugatory (*vide* Annexure I). In spite of three Five Year Plans, the per capita income has not shown any appreciable increase. It is not unusual to lay the blame on growth of numbers for this state of affairs. In spite of attention to and investment on family planning programmes since the First Five Year Plan in 1951, there has been no significant decline in the birth rate. Perhaps, this shows that the family planning programme, both at the policy and at the execution levels, has some inherent defects which need to be rectified in the light of experience, and it is for this seminar to suggest new lines of thinking on policy and administration.

This seminar is the first of a series of three seminars which are proposed to be held by the Indian Institute of Public Administration. The present paper attempts to outline the various issues relating to the policy and administrative aspects of family planning programmes to be considered by this seminar.

C. *Need for a Population Policy*

The programme of family planning was initiated about two decades ago. Since then, it has continued to be an administrative scheme passing through various stages of growth, but at no time has there been an attempt to formulate an overall policy for family planning in the context of economic development, population growth and social changes which are taking place as a result of democratic socialist ideology that has been adumbrated in the successive Five Year Plans.

The movement for a comprehensive policy statement with regard to population growth has been gaining ground since the Census of 1961, and there has been a growing awareness of the limited utility of a restricted clinical programme conceived and operated under administrative control and direction. In December, 1969, a National Seminar on Population Policy was held under the auspices of the Council for Social Development, India International Centre, and subsequently, several Regional Conferences were held, which advocated a broad-based population policy.

This seminar may discuss :

(1) The desirability of a comprehensive population policy and suggest a functional and feasible policy for adoption by the Government combining the limited approach of clinical methods under the family planning programmes and the broader approach of socio-economic development.

(2) Could the Family Planning Scheme succeed better if, in addition to the present approach of limiting a family to two or three members, we could inspire confidence among the married couples

by providing a comprehensive social security scheme as a reinforcement for voluntarily limiting the size of the family ?

Some implications of the population policy are :

(*a*) statement of the long and short-range objectives to be achieved;
(*b*) formulation of certain principles as guides for action;
(*c*) prescription of the legal, organisational and financial aspects for the implementation of the policy; and
(*d*) evolution of a methodology to secure the maximum feasible participation of the people in the formulation and adoption of the policy.

The papers which have been contributed for this seminar bring out clearly how there has been a progressive rise in the financial investments from one Five Year Plan to the other. Targets have also been fixed relating them to the narrowing down of the gulf between the declining death rate and the steady birth-rate. However, unfortunately, we do not find any debate or involvement of the Central and State Legislatures or the Local Bodies in the matter of discussion and adoption of the policy at their respective levels. This missing element of public debate appears to be largely responsible for a certain lack of commitment in the community and among the State Governments to the larger policy objectives of the family planning programmes. Two points that emerge in the family planning programmes are :

(*i*) that it is wholly a Central Government programme; and
(*ii*) that it is a programme which is purely temporary in the sense that it is assumed that it will continue for only another decade or so.

As a result of these two factors, the national commitment to the family planning programmes seems to be minimal. For these and other reasons, brought out in the various papers now circulated, it is essential that family planning policy and programmes should be discussed and adopted at various levels so that there may emerge a high level of involvement and commitment in the community for the family planning programme.

This seminar may also discuss the desirability of modifying the existing organisational system wherein health and family planning programmes are usually combined in one department. The need for a separate Ministry of Family Planning and Social Security may be examined. The desirability of each State Government having a family planning department of its own could be discussed. This discussion could throw useful light on the organisational pattern which would be necessary for creating the infrastructure committed to understanding the implications of the policy and execution of the programmes.

The basis for the formulation of targets and the pattern of incentives appropriate for fulfilling the targets deserve discussion. There is a view that target setting and incentives become more realistic and

significant for achievement, provided these are fixed in the light of statewise appraisal of the situation. In this context, the methods of evolving the necessary State authorities and local organisations assume importance.

D. The issues, therefore, are :

(1) In the light of developments in respect of the family planning programme, what are the pros and cons of a family planning/ population policy statement or resolution in the Central and State Legislatures?

(2) Should the policy be confined to family planning, or should it be broadened to cover population policy as a whole?

(3) Should there be a separate Ministry for Family Planning and Social Security or Health, Family Planning and Social Security, or should the present system of organisation continue?

(4) Should there be a Family Planning Department in each State?

SECTION II

Differential Approach to Different Territorial and Ethnic Groups

A. *The Problem*

Many studies in the family planning programme have brought to light how the responses of the people vary among different States, and among different districts within the same State. This is probably due to the varying impact of development and modernisation efforts among the different Districts or States. Experience of Community Development and other schemes indicates that a pronounced tendency among national programmes has been to place a great deal of reliance upon a uniform pattern in the matter of organisational, personnel and financial aspects of the programme. Such a uniform approach has been found to hamper the flexibility and initiative on the part of the State and Local authorities to relate the service content to the requirements of the local people. As a consequence of the lack of flexibility, some dysfunctional and disproportionate results are brought to light.

B. *Issues*

(*i*) In order to avoid such a situation, is it not desirable and necessary to make the programme a State programme with greater freedom and autonomy for the formulation of the schemes at the State level so as to encourage innovation and involvement of the local leaders?

(*ii*) How to strengthen the field organisation at the district level so that it would monitor the requirements of the different ethnic groups and prepare the programme for their specific requirements.

(*iii*) Evidence also points to differences in the responses of the different ethnic groups and religious sects. So far, there has been considerable indifference towards motivating the ethnic groups to adopt the small family

norms. What specific communication and service facilities would be required to reach the territorial or ethnic groups who are indifferent to the adoption of family planning programmes?

(*iv*) The third issue could be, whether, as in the intensive agricultural development programmes, we could rely upon the demonstration effect by concentrating upon development-prone sectors, leaving other sectors to take up the programme in course of time. In a social change programme like this, wherein political, economic, religious and other factors have a tendency to generate reluctance for or resistance to the adoption of the programme, what steps should be evolved for counteracting these forces?

SECTION III

Social and Administrative Aspects of the Family Planning Programme

A. Some of the aspects of this section have been covered in the earlier sections. However, the issues for consideration in this section are:

(1) How to counteract the cultural preference for male issues as against female issues;

(2) How to reach the newly married couples for spacing and limitation of their children;

(3) What steps could be taken to enforce more effectively the following laws :

(*a*) Registration of Marriages;

(*b*) Age of Consent;

(*c*) Child Marriage Restraint Act.

(4) Is legalisation of abortion necessary, and if so, what steps could be taken to get the necessary legislation enacted?

(5) What welfare measures are needed to facilitate the adoption of the small family norm?

(6) Could the programme, in course of time, be designated as Family Welfare Programme instead of Family Planning Programme.

B. *Administrative Aspects*

(1) Should there be an integrated organisation for the administration of health, family welfare and social security measures at the Central and State Government levels?

(2) What changes in the procedures are needed for an effective implementation of the programme at the Central, State and District levels?

(3) Is there need for better coordination, greater delegation and more autonomy for the organisations and functionaries, particularly the technical personnel at different levels? If these are necessary, what steps should be taken in order to secure for

*Since writing this paper, a law permitting abortion under certain circumstances has been enacted.

them a distinct recognition apart from the position allowed by the general pattern of administrative rules, regulations and procedures?

(4) One of the weaknesses of the family planning programme administration is that it depends for its success upon persons drawn either on deputation or recruited on a temporary basis. Could there be a special cadre for the family planning programme personnel with prospects for career promotion and commitment to the programme?

(5) Is there need for specialised training programmes for different categories of personnel on a more intensive scale than is available at the present moment?

(6) It has been found that in the absence of an organisation and personnel for a systematic evaluation concurrently with the implementation of the programme at the District and State Levels, we would be handicapped in discovering the strength and weakness of administering the programme. It is, therefore, for consideration whether there could be a built-in evaluation cell within the organisation at the local level for identifying the deficiencies and taking steps to overcome them effectively.

C. *Voluntary Organisations*

A programme of current size and complexity could seldom succeed effectively without a thorough involvement of the community and voluntary organisations in its implementation. Many attempts have been made in this direction in the past. Experience, however, shows that the Governmental and non-Governmental organisations have not been able to work as a team. The non-governmental organisations suffer from many handicaps both in the matter of organisation and in the matter of personnel, due to Government's incapacity to adapt flexible procedures for the non-governmental organisations, in respect of sanction and releases of grants and organisation and personnel matters.

Is it possible to adopt, (in view of the national significance of the family planning programme) different procedures in respect of the above matters in regard to non-Governmental organisations?

Could some sound and reputed non-governmental organisations be picked up for administration and management of the programme in some districts of a State or in some States with a view to injecting an element of competition in the administration and management of the programme between the Government and non-Governmental organisations.

Conclusion

Some significant issues from the standpoint of policy and administration have been listed. However, the participants may suggest other relevant

issues. Population policy and administration are no doubt linked with resources and personnel. They also form part of the general milieu of administration. It may not be possible to raise the level of a single programme far above the general pattern of administration in the country as a whole. But perhaps the Seminar may suggest ways and means of evolving fresh policies which could ensure the success of the family planning programme—a programme of the highest national importance.

ANNEXURE-I

POPULATION PROGRAMME INFORMATION*

Population Explosion

India, like other developing countries, is experiencing pressure of population explosion.

India has only 2.4 per cent of world's land but 15 per cent of World Population.

Position Today

Population—547 million.
Male—283 million.
Female—284 million.
Birth rate—41 per 1,000 population.
A baby is born every $1\frac{1}{2}$ seconds; more than 55,000 a day.
21 million every year.
Infant mortality—109 per thousand.
Death rate—16 per thousand; 8 million deaths every year.
Annual addition 13 million (more than the population of Australia).
Growth rate about 2.46 per cent per annum.

High Growth Rate

The main cause is not excessive births; our victory against death and disease has also resulted in addition to the population.

Death rate declined from 27.4 per 1,000 in 1961 to 16 in 1967.

Life expectancy at birth rose from 32 years in 1950 to 52 years in 1966.

Communicable diseases like malaria, small pox, cholera brought under control.

Fertility Not High

Fertility expressed in terms of gross reproduction rate in Asian countries is 3.1 to 3.5. In India it is 2.7.

Though our rate is not high, yet in terms of the large number of couples in reproductive age group (90 million) even this rate is too high.

Good Progress Nullified

Food—Food production rose from 35 million tonnes in 1961 to 72 million tonnes in 1965; but per capita food consumption decreased from 12.8 oz—to 12.4 oz—because of addition of about 140 million people.

Unemployment—Unemployment backlog in 1951-52 was 3.5 million. By end of 1965, 31 million additional jobs were created. However unemployment rose to nearly 10 million because of immediate increase in population and a consequent increase in the labour force.

Education—In 1950-51, 23.49 million children went to school. Since 1951, educational facilities expanded 300 per cent. Now, 67.5 million children are going to school.

However, 63.8 million children are still out of school, because 18 million children are being added every year.

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*Eastern Regional Conference on Population Policy and Programmes, SOUVENIR, May 3-6, 1971, p. 21.

Additional resources required annually

For the 13 million persons added to the population every year, the additional resources needed are :

126,500	Schools
372,500	School Teachers
2,509,000	Houses
188,774,000	Meters of Cloth.
12,545,300	Quintals of Food
4,000,000	Jobs

Targets

We must bring down the birth rate from 41 to 25 to avoid the explosion.

90 million couples in reproductive age group must accept small family norm.

50 per cent of these couples to be motivated to actively practise family planning in order to bring down the birth rate to 25 per 1,000. Services to be made readily available to the target population.

Choice of contraceptives to be offered.

Communication Barriers

(*a*) Large Country—We have 18 States and 10 Union Territories. These comprise 340 districts divided into 52,000 blocks, having 567,000 villages. Each State can be considered a country in itself. If Uttar Pradesh was to join United Nations, it would be the 7th largest member of the United Nations, (88 million population).

(*b*) Diversity—Many religious and cultural groups, 14 major languages, more than 200 dialects.

(*c*) Low literacy & income, Literacy, 29.35 per cent; much lower in rural areas. per capita income, Rs. 325/.

(*d*) Lack of Communication Channels. Newspapers reach about 12 per cent population.
Films reach about 20 per cent.
Radio—Community listening sets provided only in $\frac{1}{4}$ of the 567,000 villages.
Television—Only one experimental station in New Delhi covering 30 mile-radius.

Development of The Programme

FIRST PLAN	:	Rs. 15,00,000 spent 147 Family Planning Clinics established Rhythm Method Training Education Materials.
SECOND PLAN	:	Rs. 22 million spent Number of Clinics rose to 4165 Sterilization introduced. Education Research.
THIRD PLAN	:	Rs. 248.6 million spent Extension Education (1963) Mechanical Methods. Loop introduced (1965).

FOURTH PLAN : Rs. 2,300 million provided ?

Mass Education. All Contraceptive Methods. Expansion :

1 Primary Health Centre per 80,000 population,
1 Urban Centre Per 50,000 population;
1 Field Worker for every 10,000 population.

FAMILY PLANNING PROGRAMME BACKGROUND PAPER*

In its broad connotation, a population policy would cover the various State policies in political, social and economic fields, insofar as they affect population. In India, wedded as it is to planning and development, these various fields have been dealt with in the respective sectors in the successive Plans. The inter-action of high population growth and the various essential ingredients of developmental planning has been recognised from the beginning of the planning process in the early fifties.

The First Five Year Plan, while taking note of the historical precedents in the past, where rapid economic development had coincided with periods of increasing population, recognized that when India was primarily concerned with the earlier critical stages of development, a rapidly growing population would become more a source of embarrassment than of helping a programme for raising the standards of living. "In other words, the higher the rate of increase of population, the larger is likely to be the effort needed to raise per capita living standard." In this context. the urgency of family planning and population control programme was recognized and the aim set out was to reduce the birth rate as might be suited to the national economy.

The Government of India was in fact the first government in the world to adopt the national family planning policy as an integral part of its developmental plan.

The national Family Planning Programme was to depend for its progress on creating adequate motivation of the people in its favour on considerations of family welfare and providing the necessary devices and services. The Second Plan reiterated that population growth was a key factor in development. It stated, *inter alia,* "Given the over-all shortage of land and of capital equipment relatively to population, as in India, the conclusion is inescapable that an effective curb on population growth is an important condition for rapid rise in income and in levels of living." (p.7)

The Third Plan had a sharpened focus on the population control programmes, particularly in the light of the progressively widening gap between birth and death rates which was brought to light by the decennial Census of 1961. During this plan, the clinical approach was changed to extensive approach, whereunder the family planning message and services

*Ministry of Health and Family Planning.

were to be taken almost to the homes of the people. It was decided to invigorate the programme and give a central direction at a higher plane. In that context in April 1966, a separate Department of Family Planning was created.

Guiding Principles of the Programme

The programme envisages that :

(*a*) the community must be prepared to feel the need for the services in order that those may be accepted, when provided;

(*b*) parents alone must decide the number of children they want and their obligations towards them;

(*c*) people should be approached through the media they respect and through their recognised and trusted leaders and without offending their religious and moral values and susceptibilities;

(*d*) the services should be made available to the people as near to their doorsteps as possible; and

(*e*) the services have greater relevance and effectiveness if made an integral part of medical and public health services and specially of mother and child health programmes.

Since this programme implies bringing about change in attitudes and behaviour, its guiding principles are to convince individuals that the change is in their personal interest, that it is socially accepted and that it is desirable. In its implementation, the programme accordingly shuns any coercion or compulsion and depends on long-term education and motivation of the people on a sustained basis.

Integrated Approach: Yet another fundamental basis of the Indian programme is that it is considered to be an essential part of the overall developmental process and is accordingly given very high priority. The programme is associated with the social welfare and community development activities in general and health programmes in particular with special reference to maternal and child care, immunization and nutrition.

Programme Objective : The objective of the family planning programme is to bring about reduction in fertility as expressed in a reduced birth rate of 25 per thousand population within a decade or so with a view to reducing the population growth rate to 1.5 per cent per annum.

Organisational Structure : Steps have been taken for developing an elaborate multi-disciplinary organisation. The whole administrative endeavour seeks to establish a grassroots organisation for the programme. Accordingly, an impressive organisation for implementing the programme exists. There are coordinating bodies at Cabinet and Secretariat levels, both at the Centre and in most of the States. A Central Family Planning Council coordinates the efforts at federal, state and voluntary body levels. An elaborate technical, administrative and coordinating machinery has

been developed at central, state, district and local levels, both rural and urban. Regional Organisations have been developed for close centre-state collaboration.

For the purpose of motivation and providing services to the people in the rural areas, a pattern has been evolved. One sub-centre is to be provided for every 10,000 population and one main centre as a part of the Primary Health Centre for a population of 80,000 to 1,00,000 persons. In the urban areas one centre for a population of every 50,000 has been made available. Necessary staff, both medical and ancillary, is also provided.

Administration of the Programme

Under the Indian Constitution, Family Planning, like Health, is a state subject and therefore, its implementation lies largely in the state sector. The States vary vastly in size, degree of development, density and content of population, efficiency of health administration, physical conditions and many other factors. The state of administration and implementation of this programme vary from State to State, though not always in accordance with other variables.

Control Level : A full-fledged control Department of Family Planning created in the Ministry of Health and Family Planning in April 1966, is headed by a Secretary to the Government of India who is concurrently in charge of the Department of Health. He is assisted by a Joint Secretary and a Commissioner, Family Planning. Six Regional Directors, each covering a group of States, liaise with the States to stimulate the initiation of new activities, besides watching and speeding up the pace of progress.

State Level : At the State level, there is a cell in the State Health Department, and a well-staffed State Family Planning Bureau as a part of the State Directorate of Health Services which plans, supervises and ensures implementation of the various aspects of the programme. All the State bureaux are functioning with over 75 per cent of the sanctioned key staff in position. Since 1969-70, a Demographic and Evaluation Cell has also been added in many of the States. The creation of this cell is considered essential for the collection and analysis of the data and undertaking specific studies to locate deficiencies in various aspects of the programme with a view to effecting improvements.

For ensuring that highest priority is uniformly attached to the programme in all States despite differences in their resource positions, the Central Government has adopted this programme as a centrally sponsored scheme, assuring full financial assistance to the States for all approved schemes of family planning for a period of ten years from 1969. This is, perhaps, the only national programme with such a long-term assurance of continuous financial backing from the Centre.

A Cabinet Committee on Family Planning presided over by the

Finance Minister at the Centre and similar Cabinet Committees in the States headed mostly by Chief Ministers to give policy direction and to remove bottlenecks reflect the importance, prestige and high priority given to the programme. A Central Family Planning Council, headed by the Union Minister of Health and Family Planning and including the State Health Ministers, some Members of Parliament and representatives of the leading voluntary organizations and others concerned with the family planning programme as members provides the means of effective Centre-State communication. Similar councils exist at the State level. Periodically, meetings at an all-India level are held with all State Health Secretaries and Family Planning Officers to ensure coordination in operation and implementation and for removal of bottlenecks. State Administration/ Implementation Committees generally presided over by the Chief Secretary of the State, meet at regular intervals to remove inter and intra-departmental difficulties that may arise.

An organizational set-up from the Centre down to the peripheral level has been evolved as an integral part of the existing medical and health services to implement all these aspects of the programme.

District Level : At the Administrative district level, the District Family Planning Bureau forms a part of Medical and Health Organization. Headed by a District Family Planning Officer, mostly drawn from the Medical and Health services, the Bureau has administrative and other staff support. 320 District Family Planning Bureaux as against 328 required are at present functioning with 63.9 per cent of key staff in position as against 53.4 per cent at the beginning of the Fourth Plan. The key position of District Family Planning Officers is filled in 290 places out of 320.

Urban Level: For the urban population, there are 1777 urban centres of which 337 are run by Voluntary Organisations, 366 by local bodies and the rest by the State Governments. Action for bringing these centres close to the maternal and child health centres so as to supplement their efforts and also improve service facilities is being taken by the States. The staff position in these Centres is encouraging, being 83 per cent of the sanctioned posts. Usually these centres are intended for serving a population of 50,000 each; for towns with lesser population, there are urban centres with less staff.

Rural Level : Over 80 per cent of the country's population situated in the rural areas is served through rural family planning centres forming an integral part of the Primary Health Centres, each catering to a population of 60,000 to 1,20,000 or more. The rural centre has staff for different components of the programme, a doctor to plan, coordinate and supervise the work in the block and to provide services, assisted by an auxiliary nurse mid-wife (ANH), an extension educator assisted by family planning health assistants (at the rate of one for 20,000 population) for extension education and motivation work and for enumeration and record of eligible couples,

Lady Health Visitors at the rate of one for 40,000 population to help and supervise MCH and family planning work of ANMs, statistical and other staff. This staff works in coordination with the staff of the Primary Health Centre. These Centres provide service facilities for sterilization.

Rural Sub-Centres.—Under each centre, it is aimed to establish sub-centres, at the average rate of one for every 10,000 population. Each Sub-Centre is manned by at least an auxiliary nurse midwife and an attendant. It is intended to attach a male worker as well to attend to basic health work. Three Sub-Centres would be under the State Health Plan, and the remaining would be financed by the Family Planning Programme.

Against the requirement of 42,142 Sub-Centres on this basis, 29,933 (71.0 per cent) are at present functioning (inclusive of 14,175 sub-centres opened under the Health Programme). These are responsible for IUCD insertions and supplies of conventional contraceptives and act as focal points for the educational and motivational work.

Considerable progress has been made in the matter of the setting up of Rural Centres and staffing them during the last four years. At present, as against the requirement of 5,427 main centres, 5,100 Centres are operating, of which about 500 have been opened since April, 1969. The staff position has also improved from 37.4 per cent at the beginning of the Plan to about 71.0 per cent at main and sub-centres. A second doctor is operating at about 1800 centres, of whom over 1000 have taken position since the commencement of the Plan.

Contraceptive Methods and Devices and Their Adoption

The programme follows a 'cafeteria' approach. Eligible persons are free to choose any of the scientifically approved and tested methods of contraception. The spectrum of available methods includes the loop (I.U.C.D.) insertions, sterilization (both male and female) and conventional contraceptives like Nirodh (Condoms), foam tablets, jellies and diaphragms. The oral pill is in a pilot demonstration stage and its further extension will depend upon evaluation of the results of the project.

In the case of loop and sterilisation, some compensation by way of out-of-pocket expenses is paid to the volunteer, the motivator and the doctor. The compensation is Rs. 11 for IUCD and Rs. 30 and Rs. 40 respectively for vasectomy and tubectomy. A larger amount is paid for tubectomies involving feeding charges and special charges for the organisation of camps.

The total acceptors at the end of 1964 on account of sterilisation since its inception in 1956 and the users of conventional contraceptives was around one million. Since then over eight million persons have undergone sterilisation and 3.7 million loops have been inserted. Over one million persons use conventional contraceptives. Since 1967-68, the number of acceptors,

mostly additional, has tended to stabilize around 3 million annually, the number during 1969-70 being about 3.4 million.

The following table indicates the progress during the year 1969-70 and 1970-71 (up to February, 1971):

	1969-70	1970-71 (up to Feb., 71	1969-70 (Up to Feb., 70)	Cumulative since inception	Rate per 1000 population
Sterilization	1422118	1142151	1252921	8,482,108	15.5
I.U.C.D.	458726	407741	398978	3,736,616	6.8
C. C. Users	1515329	2037284*	1417912	2,037,284*	3.7
Total acceptors	3396173	3587176	3069811	14,256,008	23.0

*Equivalent number of C.C. Users.

The number of couples in the reproductive age-group who have been currently protected by the various contraceptive methods available under the programme is 10.7 millions, that is 11.1 per cent of the total number of such couples. There has been a slight decline in the number of sterilization cases but a perceptible increase in favour of tubectomies; the percentage of tubectomies of late has gone up from 26 per cent in 1969-70 to 32.5 per cent in 1970-71 (upto February, 1971). With a view to providing facilities for the rising tempo of tubectomies, the States have been asked to allow reservation of beds in private medical institutions besides constructing additional sterilisation beds.

There is evidence to indicate that the age of acceptors of various family planning methods has been progressively coming down. With the improved quality of services, especially pre-insertion or pre-sterilisation check up by the doctors and subsequent periodical follow up, the use-effectiveness of loop and other contraceptive methods is now higher than before.

An Expert Committee was set up under the chairmanship of Prof. C. N. Vakil to examine the question of targets for the Fourth and Fifth Plans and to recommend realistic targets keeping in view the inputs, present and potential and also the objective of bringing down the birth rate from 39 by seven points during each of these two plans.

Conventional Contraceptives : Amongst the conventional contraceptives, the use of Nirodh (Condoms) has been gaining in popularity. With the advocacy of the idea of spacing as a sound and healthy method of family limitation and supplies of Nirodh becoming comfortable and assured, through gifts from friendly countries like U.S.A. and Sweden and on account of indigenous production, the consumption of Nirodh has been on the increase.

Besides free distribution of Nirodh through Family Planning Centres

and clinics which has been showing an upward trend in the various States, Nirodh is being made available through commercial outlets at a price of 15 paise for three pieces, and through depot holders, mainly rural post offices, at a price of 5 paise for three pieces. The commercial distribution has increased from 15.74 million pieces during 1968-69 to 48.3 million pieces during 1970-71 (upto February only). Cumulative All-India sales during April–February, 1972 have registered an increase of 83 per cent over the corresponding period of 1969-70. The Depot Holders Scheme is also getting under way with the selection of 14,448 post offices. It is proposed to extend this to agencies like cooperatives, *Patwaris* and others.

Other conventional contraceptives which are for use by women (foam tablets, jellies/creams and diaphragms) have less consumption because of the lower degree of their effectiveness and lack of adequate physical facilities.

Besides the oral pills which are in an experimental stage, other contraceptives which are also being tried out on a small scale are minipills, injectibles and implants.

Training : Training constitutes an important ingredient of the programme and is imparted through 5 Central training institutes, 44 (against 46 needed) Regional Training Centres and 16 Mobile Field Units. The number of Regional Training Centres increased from 25 in 1966-67 to 33 in 1967-68, to 43 during 1968-69, and 44 in 1969-70.

The Central Training Institutes train the key personnel, besides providing leadership to the Regional Training Institutes in their respective regions with technical support and guidance.

The 44 Regional Family Planning Training Centres have the prime responsibility for organising training for the block level servicing staff. They are required to have the field practice and demonstration areas, both urban and rural, attached to them so as to provide meaningful experiences.

Central Family Planning Field Units—16 in number—support and supplement the existing training resources of the States and impart job training and also conduct community education programmes in their allotted regions. They have also been carrying out some studies in the evaluation of the programme.

About 600 private medical practitioners have been trained in Family Planning through orientation-cum-training courses conducted by the Indian Medical Association at Delhi.

For integrating knowledge of family planning techniques in the medical colleges, the Medical Council of India has included it in the curriculum prescribed for medical colleges.

Knowledge of family planning has been inducted into the general Nursing and Midwifery Courses for Lady Health Visitors and A. N. Ms. etc. 207 sister tutors have been given orientation training for this purpose through Regional Workshops and a manual has been prepared for this

purpose for their use.

Indigenous *Dais*, who have an important role to play in the rural areas, are also being trained. The Fourth Plan provides for the training of 75,000 *Dais*. Training in Demography is available at the International Institute of Population Studies, Bombay and also in some universities.

Mass and Extension Education

The Family Planning Programme, based as it is on voluntary acceptance by the people, requires large-scale efforts at constant education and motivation of the people. The strategy so far has consisted of a few meaningful, positive and easily understandable messages continuously repeated to the public through a variety of modern mass communication media and also through traditional media. The main message till recently has been of limitation of the family to two or three children. The inverted equilateral red triangle, which is the national family planning symbol and the design of a happy family consisting of four stylised faces of a father, mother, son and daughter have been identified with the programme all over the country.

All the mass media units of the Central Government, namely, All India Radio, Television, Field Publicity, Advertising and Visual Publicity, Exhibitions, Song and Drama, etc., have been involved in spreading the message of family planning.

In the States, the Information and Publicity Departments work in coordination with the publicity undertaken by the State Health and Family Planning Directorates for family planning. Mass media coordination committees at the Centre as well as the State level bring about the required pooling and planning of all the inputs and efforts for getting proper results.

Various voluntary organisations and social bodies, such as Rotary Clubs, Lion's Clubs and Mahila Mandals have been involved in creating mass awareness.

The Department of Family Planning has been considering whether the old approach would hold good for pushing the programme forward in the developing situation. The fact must be acknowledged that as against massive awareness, the actual practice of family planning is confined to about 16 per cent of the eligible couples.

It has been increasingly felt that this strategy needs further orientation and modification so as to bridge the gap between awareness and actual acceptance.

It is obvious that in the light of the experience in the last few years, a stage has been reached when the evaluation of the relative effectiveness of the various media and messages and slogans and research in evolving better techniques with the help of specialised agencies are necessary for the optimum use of mass media.

Extension Education : Extension education through group and

individual approach supports and supplements the mass education strategy. Besides the extension educators, health assistants and auxiliary nurse mid-wives, this important aspect of the programme is also extended with the help of village leaders and prominent members of *Panchayat* Administration in the Rural Areas. Lately, active involvement of *Satisfied Customers* for extension education is being investigated.

Voluntary Organizations : The prelude to the initiation of the official family planning programme in India was the initiative of voluntary organisations. The work of some of these organisations had indeed been excellent in creating a favourable climate. Adoption of Family Planning Programme as a national priority scheme for implementation through various levels of Government administration has not, however, detracted from the key role that the voluntary organisations can play in making this programme a mass movement. In fact, this aspect has been recognised all along and it was considered that full assistance to the voluntary organisations for their activities relating to family planning should be forthcoming from Government as a part of the programme effort. With a view to involve even those voluntary and social organisations which have a limited field of operation, the authority to give grants-in-aid was delegated to the State Governments. The voluntary organisations have been involved in motivation, services and training aspects of the programme. Voluntary Organisations are treated as full partners in the programme.

Organized Sector : Another field which has promised good results by concentration of resources is the organised sector of the economy both in the private and public areas. It is estimated that the organized sector industry and establishments employ 12 million workers. The chief characteristic of these workers is that their vast majority are adults and thus fall within our definition of those eligible for family planning. Accordingly, an organized sector programme has been undertaken which involves railways, defence forces, mines, tea plantation, P & T., Public Sector undertakings, industrial establishments and is being steadily expanded.

Research : Research on various projects in the field of bio-medicine, demography and communication action having immediate as well as long range bearing on Family Planning Programme is financed by the Family Planning Department.

Bio-medical Research is carried out through the agency of Indian Council of Medical Research and the Central Drug Research Institute, Lucknow. The Research is both basic and applied. Certain universities and institutions are being given support on a regular basis for research in reproductive physiology. Over 40 projects are under way all over the country in the field of reproductive biology and fertility control. Anti-fertility drugs, the causes of various side effects arising out of the use of IUDC experiments with indigenous and other preparations showing good anti-fertility effects, follow up of IUCD cases from the medical point of

view, personality changes in women undergoing IUCD and vasectomy treatment, bio-social studies and controlled clinical trials on various contraceptives are among the areas covered by the bio-medical studies research.

Demographic and Communication Action

In the field of demography and communication action, 9 Demographic Centres and 8 Family Planning Communication Research Centres have been established. The objective is to establish at least one Centre in each State. The leading institution in the field of demography is the International Institute of Population Studies at Chembur. It undertakes research on a regional basis both in India and in some other countries in the ECAFE Region.

There are about 200 studies on sterilization, 150 on IUCD, 240 on K. A. P., and 200 on fertility. There are also studies on other related subjects like mortality, migration, urbanisation, population projection and age of marriage. Research work in population, simulation models, probability models is also undertaken by selected institutions. Preparatory steps are being taken to institute cost benefit studies.

The follow-up studies have helped in determining the demographic effectiveness in various family planning methods and in estimating the number of births which are likely to be averted in different years as a result of various family planning methods. It is estimated that as a result of the work already done upto 1968-69 about 34 lakh births have been averted. Tfie total effect of the work done upto 1968-69 on future years upto 1978-79 will lead to approximately 15 million births being averted. There will be additional perspective prevention of births even beyond the year 1978-79 as a result of the work already done.

The research in the field of demography and communication action is coordinated with the help of an expert committee, namely, the Demographic and Communication Action and Research Committee. The Central Family Planning Institute coordinates the research activities in these fields and also acts a clearing house cum documentation centre for effective utilisation of research in the programme.

Evaluation : Concurrent evaluation is undertaken in the Department of Family Planning through the Evaluation and Intelligence Unit. This Unit has also been undertaking studies on age, parity, community and educational characteristics of sterilised persons and IUCD users.

In the States, besides the statistical staff provided at various levels, a Demographic and Evaluation cell has recently been provided to undertake specialised evaluation studies in connection with the various inputs of the programme, including deficiencies in certain areas of the programme.

Vital statistics continue to be a weak area in India as in most of the

developing countries. The effect of the Family Planning efforts on a nation-wise basis are, therefore, not easy to arrive at. The decennial census provides at least a part of the answer. A reduction in periodicity as suggested by the UN Mission will involve heavy cost and stupendous organisational problems. The fertility follow-up and KAP studies being undertaken in various parts of the country provide useful data during inter-censal periods. The Sample Registration Scheme of the Registrar-General of India is proposed to be augmented and refined so that this becomes a useful index in this direction.

Performance budgeting and cost studies with reference to various inputs in the programme are also being increasingly developed. Periodic independent evaluations are done by independent evaluation agencies.

PAPERS PRESENTED

AT THE

FIRST SEMINAR

FAMILY PLANNING POLICY —RETROSPECT AND PROSPECT

ASOK MITRA*

Very deservedly, Family Planning has in the course of the last decade acquired supreme importance. This is an area of conceptualisation, research and operation, which has become the meeting ground of various policies and disciplines, each benefiting and modifying the other. Along with migration, family planning is the most direct instrument of a population policy, whether on the national or on the individual level.

Thanks to assiduous public health measures, along with better distribution and availability of food, mortality has spectacularly declined, particularly at the early ages, convincing every parent that it is no longer necessary to raise a number of children to guarantee the survival of only a few. Even infant and child mortality, although still comparatively high, has been reduced by more than half in the last twenty years, so much so that a parent now feels reasonably assured that once a child has reached the age of six, it can survive to the full span of life. It is, therefore, unnecessary for him to have children by more than a margin of, say, 20 per cent of what labour he actually requires for the economic activity of his family. In the light of this plain conviction, one feels reasonably certain that the small family norm would come sooner and more universally in the developing countries in the last third of the twentieth century than it did in the countries of the West, which took a much longer time to reduce mortality. In the matter of improvement of public health and distribution of food, the developing countries have caught up to a large extent with the West and have provided the preconditions for the small family norm. But, in the matter of creating the conditions themselves for sustaining the small family norm, a fuller transformation still awaits the developing countries. Without this transformation, it is possible that the developing countries will still hold out the promise but not the fulfilment of the small family norm. This transformation seems to lie through the adoption of universal literacy, the resolute removal of acute inequalities of income that grievously constricts the savings and consumption of large masses of population, the replacing of subsistence by economic choice, and particularly by affording the child-bearing half of the population, that is, women, the means of education, employment and income.

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These naturally bring in their train the entire universe of agriculture and industry, internal migration and redistribution of population since all such demographic phenomena are ultimately motivated by a person's desire and strength to accomplish an economic choice of his own. The small family norm is inextricably interwoven with the freedom to make this choice. The greater the freedom of the choice, the easier seems to be the manipulation of births, whether consciously or unconsciously undertaken.

Nowhere is this more aptly illustrated than in the recurring phenomenon of post-war baby booms. A variety of reasons—biological, social, economic and even metaphysical—have been offered by way of explanation. But irrespective of the size of human loss, disruption of sex ratio, biological and impersonal urges of life wanting to triumph over death and so on, the invariable attribute attending these baby booms has been scarcity and rigour leading to the curtailment of consumption and employment opportunities in the period immediately following the cessation of war until reconstruction sets in. It has been noticed that baby booms disappear with the emergence of post-war reconstruction booms and economic expansion. This may well seem a drastic over-simplification of the economic theory of population, but in recent years considerable work has gone into the effect of economic changes on the size and structure of the family and on the effects of economic variables on human fertility. Outstanding work on the influence of economic variables has been made in this field by scholars like Gary Becker, Jacob Mincer and Milton Friedman. Becker, for instance, treats a child as a consumer durable and analyses parents' demand for a child in terms of basic economic variables like prices and income, the same way as the demand for any consumption good is studied. Friedman concludes that children are both a consumption good, as a source of direct satisfaction, and an investment good, as a source of income and a means of obtaining good, as a source of income and a means of obtaining security in old age. He goes on to say that "from this point of view, children are to be regarded in a dual role : They are a type of consumption good, a way of spending one's income to acquire satisfaction, an alternative to purchasing automobiles or domestic service or other goods; and they are a type of capital good produced by economic activity, an alternative to producing machines, or houses or the like". Jacob Mincer has made detailed studies on the effect of business cycles on fertility. Incidentally, the perceptible rise in the size of the family in the American continent may be due to the fact that saturation has almost been reached in the satisfaction of acquiring houses, automobiles or domestic appliances or other goods, and one of the worthwhile outlets of being of service to the nation is by having more children and raising them properly.

None of these studies are by any means farfetched even when applied to the conditions of developing countries. As a matter of fact, these

statements seem to fit these conditions even better, where the choice, both in consumption and investment, is far more limited than in developed countries. So much so that both satisfactions seem to merge more readily in an underdeveloped country in producing more children, because the range of consumption good is so limited in the rural scene and almost the only capital good, that a small farmer or an agricultural labourer can hope to acquire, is an additional increment of two hands for more labour.

The situation becomes even more difficult when within the selfsame developing country two or more strata appear, one almost at the level of literacy and material and industrial well-being, comparable with any obtaining in the developed world, and another much wider and thicker, living almost on the level of illiteracy and subsistence, and incapable of voluntarily exercising economic choices. The situation becomes still more complex when, bereft of the power of exercising economic choices, these levels, while acknowledging the validity and even desirability of accepting the small family norm, are yet deprived of the means and objective motivation of accomplishing it.

Obscurantism enters at this point, when we proceed to apply double standards and try to separate the twin process and claim that it is possible to attain the small family norm of a highly literate, materially and industrially developed society in societies with limited literacy, material and industrial development, where subsistence economy still obtains in large areas where a surplus of fresh human stock is the only tangible capital that can be invoked.

The enormous agro-technological revolution which bids fair to overrun the developing countries will have the result of rendering the top of the agrarian pyramid steeper and slimmer, than ever before. Even if sufficient quantities of foodgrains or other crops are produced to the point of becoming surplus and generously exportable, land tenure conditions will still continue to impose severe restrictions on the enlargement of consumption in rural areas, because too few would be producing too much to be able to sell at expected profits and there would still be too many unable to work for reasonable returns to enable them to produce or buy in sufficient quantities. Unless the fruits of the agro-technological revolution are made equally, or rather preferentially, available to the lower and wider bases in the pyramid, the backwash effect of poor consumption in the wide base will endanger the growing stability of the top. It has to be recognised that unsatisfactory land tenure conditions still play an overwhelming part in the backwardness of our agriculture because they prevent the effective application of proved technological improvements. Vast latifundia contrast with myriads of small holdings and often the evils of both are combined by having latifundia worked by sharecroppers or small tenants on a minifundial operation unit basis. The pattern varies from region to region with varying rates of absorption of rural manpower.

But the system itself perpetuates inequalities of income and, in fact, contributes to the growing gap between the rich latifundia and the poor minifundia, comparable to the widening gap between rich and poor countries. It is true that the profit motive has freshly enthused the latifundia in the area of green revolution but this motive alone is insufficient to sustain and bring about the full development of agriculture. It will be argued that, in spite of minifundia, spectacular progress has been achieved in agricultural production in most developing countries. Of this, there is incontrovertible evidence and no doubt. But this has been possible in spite of minifundia and not on account of it, and one cannot help wondering how much more would have been possible, were minifundia done away with. For, in minifundia, the profit motive is blocked in the first place by the physical impossibility of single, small owners carrying out improvements in production techniques. Organisation of improvements becomes difficult, if not impossible, in the absence of overall control, for nobody knows how his work will fit in with that of the others, who should give land for irrigation canals and where the compensation would come from, or on what basis one is to be remunerated. Even more important and insidious, however, is the blockage due to what I have discussed elsewhere as the credit factor. Minifundia are usually subject to crushing amounts of debt and the moneylender is in a position to take the whole surplus of the small holding. The peasant thus has no interest in getting into debt in order to improve his production methods—and the classical incentive mechanism is again stultified. Nor is the peasant able to tap the capital market on any reasonable terms.

The results manifest themselves in many demographic forms, the most grievous of which is the steady flow of personnel at very young ages of the slightest education or skill from minifundia areas. This amounts to punishing the young and preventing them from improving the soil of their birth and leaving it to continuing neglect in the hands of an incompetent and older generation. Nowhere is the younger generation punished more severely than in areas of minifundia. Owing to this phenomenon, the backwash in all other economic activities readily follows together with such demographic phenomena as high fertility and high mortality, lack of transfer from agriculture to industry, lack of cross-fertilization between rural and urban areas and lack of diversification of economic skills through lack of consumption and investment. The chiefest to suffer are education and employment of women in independent economic activity for in these areas even teachers are difficult to raise or import and female labour must be employed to take what should naturally be the younger generation's work at home.

Thus, family planning can only be conceived of as one measure among many, all of which are intended to overturn or at least transform the old social and economic structure. A programme of this kind could only be

adopted by a population in the midst of experiencing a veritable revolution of the structure of the family and the household, the ultimate unit of economic organisation in society which is in its turn associated with profound economic and social change. The prodigiousness of this process which must be supported by the upheaval of a social structure, in particular, of the family, is scarcely realised in its full implications by the protagonists of family planning even when such a programme has been adopted as a national policy. Too often, the old mental inertia still persists that family planning can be brought about on a national scale without disrupting the old social structure or the established values of the family, so much so that although the mutation of these social structures is in the process in developing countries, there is much tardiness in recognising them, far less in welcoming them. Family planning is often facetiously equated with economic development, but the former is not a substitute for the latter. To apply a family planning programme does not mean renouncing decisive and energetic action with a view to economic development. On the contrary, economic development remains the primary objective and demographic action is complementary to it.

Alfred Sauvy, in his General Theory of Population, proposed that a distinction should be made between demographic investment and economic investment. By demographic investment, he meant those that are necessary to maintain the level of living at its present level; that is to say, investment, the sole purpose of which is to meet the growth of the population. By economic investment, he meant those which permit an improvement in the level of living of the population. Put in these terms, it is to be feared that demographic investment in most developing countries is not, at any time, far behind devouring the resources available for economic investment unless human fertility is restrained by conscious means.

Apart from development in the study of family planning, the most recent techniques of contraceptive devices have provided an entirely new element. The arrival on the market in 1960 of oral contraceptives, followed in 1962 by the renewal of intra uterine contraceptive devices, have permitted a healthy and scientific dissociation in the human mind between contraception and the sexual act.

This has extended dissociation in other spheres, too. For instance, many developing countries have adopted insinuative symbols for the family planning campaign or family planning clinics, like the inverted red triangle in India which has also brilliantly brought about a welcome dissociation between what is essentially a personal, as well as national, economic and social goal and the sexual act. On the national plane, too, this dissociation has made possible extensive application of the mass media which seek to resolve the dichotomy between a national goal and a personal goal. It is not always easy to distinguish national planning policies from family policies but there are aspects of each which ought to be harmonised with one another.

In developing countries the demographic attitude prevails though the family policy is of course not neglected. In developed countries, family planning programmes have come to stay mainly as family objectives : the aim is to enable each family to have the exact number of children it wants. Contraception is of course widely practised mainly to enable the family or the individual aspect to take precedence over the demographic aspect.

This dichotomy between what is essentially a national goal, population control and reduction of the national birth rate, and what is really a personal goal and ideal, family planning, between what is essentially a means and what is really a personal or family ideal or end, has plagued the family planning communicator in all countries in recent years. This has had repercussions on the methods and organisations and even publicity programmes advocated or adopted. What is more, wherever the dichotomy has been allowed to continue in conceptual confusion and indistinctness, the methods, targets and organisations have also suffered from attendant confusion and travail. This has happened even in China, where reportedly the greatest willingness and evangelical fervour exists to "require the dedication of the individual to the goals of polity and power". Despite "the revolutionary shifts from the traditional ways of a disintegrating order to the compulsive reorientation of evangelical communism" (Irene B. Taeuber and Leo A. Orleans), the General Line has repeatedly failed. This has happened more conspicuously in Japan, in South Korea, in Taiwan, in the West African countries and the socialist countries still grappling with the problem of rapid development.

Population control is the national goal, as a means to social, cultural and economic prosperity, but it is presented by the Government in terms of individual health and welfare as a personal goal, an ideal, an end in itself. But dichotomies in concepts, methods, organisation and means are apt to arise from time to time demanding fresh resolution at each dialectical point. Thus, as a bridge between the national and individual goals, between the means and the end, the *cafeteria* approach has been most favoured as a consequence of which a citizen has the run of a whole range of choices : condoms, jellies, diaphragms, rhythm, coitus interruptus, continence, pills, male and female sterilisation, IUCD, and even advocacy of abortion. But in spite of the cafeteria or free choice approach, the Government has, in the very nature of things, to insist on one or other particular method and press them as more equal than the others to put the right load of traffic on and justify the organisation it creates and trains. Secondly, the channels of communication are both Government, representing polity and power, and voluntary, representing the social elite transcending power, the makers of public opinion, the manipulators of cultural orientation, the representatives of social, cultural and local prestige. It is not unoften that these parallel channels representing, on the one hand, the compulsions of a committed means and, on the other, the forces of

social engineering, working for the acceptance and avowal of a private end or ideal, come into conflict and present conflicting aims and communication approaches. While one may insist on physical targets and feel confident of the organisational and operational set-up for achieving them, a voluntary organisation may find that the cultural orientation of the population has not been desirably looked after. Or, conversely, as has reportedly occurred several times, a voluntary organisation may have laid on the motivation campaign quite satisfactorily and brought about the right pitch of orientation, only to find that the Government or institutional amenities that might have ridden happy on the crest of this effort, had fallen short. Then again, the Government machinery on the one hand and the social engineering elite on the other might well find themselves differing over the actual technique to be employed ; the government, to take a hypothetical case, insisting as a matter of routine on sterilisation of either husband or wife as soon as a stated number of children is born; the motivating elite, on the other, protesting that the national means would not suit this particular population as this would "result in much frustration and the development of guilt complexes with frequent psychosomatic disorders" (Adaline P. Satterthwaite). Fourthly, sharp differences are likely to arise over suspicions, real or imagined, that politics is being imported into eugenics, or the interests of particular communities, sections or classes, are sought to be either affected or served. For example, it has been held that there are small communities in most large countries which feel they owe it unto themselves to keep their birth rate ahead of the average. Fifthly, there are differences in selecting the motivating elite itself. The Government, in insisting on time-bound targets, may feel inclined to rely heavily on established cadres or hierarchies that are in the direct line of polity and power. The upper and middle echelons of the Government machinery, charged with the behest, may naturally gravitate towards the elected *panchayats,* the local administrators, the wielders of money, favours and opinions as being 'those who can really deliver the goods' and prefer them to persons like school teachers, social reformers, respected technicians and professionals, tending to dismiss them as the long-haired ones, but whose prestige may, in reality, be effective enough to transcend polity and power. It may even take the government machinery some time to discover that the so-called go-getters may be actually baulking the programme by setting up a double front, being too readily identified with one or other power or political faction, and therefore rejected by other groups, and often too firmly wedded to traditional values and prejudices to pay any but the merest lip-service to new ones. An illustration or two will explain the point. For instance, it has been observed that husbands and wives who express more liberal views on the desirability of their sons or daughters marrying outside of their castes or community use contraceptives more frequently than those who frown upon deviations from the traditional

mores of arranged marriages. Again, a positive association has been noticed between approval of education and outdoor employment of daughters and acceptance of contraceptive devices (C. R. Malakar). To take a second example, it has been observed in an urban clinic that women in the age group 23-27 attend most, with young women in age group 18-22 following closely behind (Kirtikar and Virkar). It seems hardly likely that the majority of *sarpanches* or *panchayats* in India will approve of such trends. This is possibly the reason why non-government organisations often insist that motivators and communicators should be selected with great care and should be cultural leaders, dissociated from power. This, they argue, helps to bring about the desired fusion between national and private goals.

I have spoken of the dichotomy between what is essentially a national goal—population control and reduction of the national birth rate—and what is really a personal goal and ideal—family planning. What is not often realised or openly acknowledged but is nevertheless providing an obstacle to sub-national, regional or local commitments to the national goal of population control, is the factor of population itself which directly determines the size of financial and political benefits and allocations between the Union on the one hand and the sub-national, regional and local bodies on the other. This builds in and perpetuates unspoken but stubborn areas of conflict between national and sub-national interests over population growth.

According to the Constitution and the conventions that it has developed of sharing taxes and revenues, almost all forms of financial and material allocation as well as political and administrative representation are largely determined in direct proportion to the size of the population that a region can muster. In short, the larger the population, the larger the size of the cake for the local body. In any federal system, committed to removal of regional disparities and to equalisation of incomes, it is difficult to think of securing acceptance of any formula that takes a contrary stand by seeking to punish populations growing at undesirably rapid rates and rewarding those that are declining. Even if, therefore, reduction in the national birth rate should be the professed ideal, it is impossible for the federal government to mete and dole unequal, even if logical laws, to growing and declining sub-national or regional populations. And, so it happens that in any manner of allocation, whether of the divisible pool of central receipts or of the periodic allocations by the Finance and Planning Commissions, or of the phased rectification of regional imbalances and of backward areas, the size of the population cannot but play a positive role. The size of the population as a determinant of fringe benefits to individuals and families has extended even to cities and towns where it determines the quantum of the city compensatory and related allowances. As a result, local bodies have now acquired a direct vested interest in the encouragement of slums, jhuggies and other insanitary habitations, promot-

ing indiscriminate growth of population, if only to qualify for certain allowances for a small proportion of their privileged populations.

The point that is sought to be made is that each sub-national unit of the country is interested in registering over the rest a differentially higher rate of growth of population in each decennial census, because it is this higher differential rate of population growth that will gain for it a larger slice of the national cake. It is difficult to remove this subconscious urge in a regional administration and to expect the latter to dedicate itself wholeheartedly, to its own obvious detriment, to the national goal of population control. Much concern has repeatedly been expressed over the tardiness of the individual States in adopting strong resolutions in their respective legislatures on the need of a more aggressive family planning policy and underpinning it with adequate administrative and voluntary machinery. But even if the States were to adopt the strongest resolutions, they would still suffer from some of the ambivalence or equivocation that is noticed among minority communities in a nation who, although mindful of the need to reduce their populations, yet strive, however unconsciously, for a higher differential rate of growth to retain their place in the sun. Thus, in spite of their avowed commitments expressed in conferences, the States feel reluctant to accept the full commitments of non-Plan expenditure and are never so happy as when the Centre continues to shoulder the entire brunt of the expenditure on family planning by perpetuating the scheme as centrally sponsored. By the same token, voluntary as well as government organisations are pushed by the States to rely almost entirely on central support. It also gets rather difficult for a State Government to earmark funds for the special training of the different cadres of the family planning organization, to provide for compulsory or national service regulations particularly for these programmes, and to support special incentives and hardship allowance for the prosecution of the family planning programmes in difficult and inaccessible areas. It also proves difficult for the States to provide extra funds for the special building or transport programmes for the family planning programme; or to earmark allocations for specialised instruction and training.

It seems, therefore, that the attainment of what is essentially a national goal of population control through reduction of the national birth-rate, will have to wait until the preconditions for the attainment of the personal goal and ideal of family planning are attained and are made to overtake the race of the national goal. That is, conditions must be provided first for the quicker attainment of the personal goal of family planning, enabling it to overtake the sub-national or regional administrations in achieving the national goal. In short, the preconditions for attaining the personal goal must move appropriately faster than the effort of the State in subduing its desire for a differentially higher rate of population growth over the rest.

This will demand almost equal and simultaneous attention from the States in two directions which, although apparently contradictory, are essentially complementary inasmuch as the family planning programme is likely to succeed more readily where equal and simultaneous attention is paid to both. The first course will naturally lie in greater attention and emphasis being paid to family planning and to a far more determined implementation of the family planning programme than has been hitherto attempted. For this purpose, each State must be exhorted to undertake the appropriate policy resolutions once again in their State Legislatures and Executive Cabinets and commit their administrations to an adequate and determined support of the family planning programme. On the other side, whatever supports the quicker attainment of the personal goal of family planning can no longer be neglected or allowed to go at half speed. The first requisite in this direction seems to be to complete the unfinished revolution in public health measures that the country still suffers from, the broadest requirements in this direction being protected water supply, improvement of general sanitation, rapid reduction of communicable diseases, efficient systems of sewage and sewerage disposals, and universal triple immunization, all calculated to guarantee the survival of the infant. In the next phase, child-rearing must be made increasingly costly with the introduction of compulsory primary education up to the age of adolescence which will remove the young child from domestic, own farm, agricultural or pastoral chores, while still very young. It is important that this primary education should have a functional quality by having part work and part study in the curriculum, the work being related primarily to the economic culture of the locality. A further step towards the survival of the infant child needs to be provided in the form of nutrition to expectant mothers in the last three months of pregnancy, to nursing mothers in the first months of child-birth and to infants between the age of six and nine months at which age the triple immunization must be enforced.

It has long been imagined that the birth rate automatically declines with growing urbanisation and industrialisation. But in developing countries neither urbanisation nor industrialisation has been accompanied by a completed public health revolution or primary education, or higher nutrition or public housing with appropriate environmental sanitation. Even immunization in large cities and industrial areas can be as bad as and even worse than in rural areas. It is, therefore, all the more necessary to address the family planning programme to the rural areas and create the wherewithal on which alone the programme can thrive. One of the first means by which the programme can be made to thrive will be to make the labour of the child or the mother much more costly than the acquisition of simple labour-saving devices and tools in agriculture, like the simple drill or hoe or tiller or the irrigation pump or the small and commonly used winnowing and threshing machines, etc. It is now quite

clear that the green revolution will demand more mechanical and powerdriven implements even on the small farm, the need of which can no longer be wholly met by human labour alone, for the latter proves too costly for small enterprises. It is often imagined that the small and marginal farmer does not need these things because of the plentiful labour supply at his command through his own children and women. But unless this supply now so accessible to him, as time goes by is made to prove comparatively more costly than an array of readily acquired agricultural tools and implements, family planning in rural areas is unlikely to make any significant impact. It is also important to raise rural wages through a large variety of rural works on which women can be employed on continuing wages, for unless there is increasing employment of women both in rural and urban areas, the call on them for childbearing will continue to be heavy. It must be remembered that even gainful self-employment or employment in own farm can be no substitute for employment or earning outside of one's home or of one's own farm.

All this, one will say, really adds up to an increasing standard of living and a rapid transformation of the old social and economic structure. Unfortunately, there does not seem to be much of a short-cut to this twin approach in support of an aggressive family planning programme. The census results of 1971 themselves reflect signs of the efficacy of the family planning programme in those areas alone where this twin programme has started bearing fruit. The guarantee of nutrition and health and the guarantee of livelihood are the two best guarantees for the quick success of family planning.

SOME EMERGING ISSUES IN FAMILY PLANNING ADMINISTRATION

ASHISH BOSE*

This paper makes a plea for the integration of family planning, not only with health services but also with a minimum programme of social security. The Ministry of Health and Family Planning should be expanded to include social security also. By social security we do not mean "Social Welfare" as understood by the Planning Commission—care of the handicapped and the destitute—but a well-thought-out programme for sickness insurance, unemployment insurance, old age pension, etc. In launching such a programme, the Life Insurance Corporation should play an important role but this calls for considerable innovation.

It is too late in the day to argue that India cannot afford a social security system. The die has been cast. The people have been aroused and the *garibi hatao* slogan must be translated into action. People will demand positive steps and not negative slogans like "two or three children enough", "after three never". What is the hope for people who practise family planning ? Can the Government continue to deny them security in old age and yet demand from them adherence to a small family norm? There cannot be any commitment on the part of the people without a commitment on the part of the Government. It is time we realised that Western style advertising through all the mass communication media may yield negative results in this country. One of the myths of family planning is that reproductive behaviour in a country like India can be changed by propaganda and posters.

Is it logical to expect that the illiterate Indian masses staying in primitive rural areas, depending on subsistence agriculture, will take to the modern idea of family planning and a small family norm, other things remaining the same ? Is the small family norm not a part of the process of modernisation and social change, a part of the transformation of a traditional society into a modern society? As long as daughters are not viewed on a par with sons, as long as the dowry system persists, as long as people are left at the mercy of their children for their maintenance in old age, how can the idea of a small family catch on ? It is not a question of having only two or three children, as our posters say, but two or three

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sons, because an average family will feel secure only when there are two or three sons. But in the process of getting three sons, a couple may get three daughters as well. In any case, the evidence from the several family planning attitude surveys reveals that an average family does not desire more than one or two daughters, and there is indeed a strong motivation in India against having too many daughters. But have we taken any advantage of this in our family planning propaganda? On the contrary, our posters saying "two or three children are enough" invariably show one son and one daughter but never only two sons or only two daughters. Thus the son-complex is ingrained even in the minds of the poster designers. The family planning movement in India must counteract the prejudice against daughters, and this means social reform, and even deliberate preferential treatment of women in the spheres of education, employment, etc. It may be noted that in the tea gardens where women workers are preferred, there is no prejudice against daughters : in fact, daughters are preferred to sons by the working families there. It is, therefore, necessary to devote our energies to more substantial measures than designing posters, if we wish to influence reproductive behaviour. Also, a minimum social security plan has to be formulated and implemented. It is not enough to give old age pensions to destitutes. A socialist society should surely concern itself more solidly with social security programmes.

We must abandon the present restrictive clinical approach to family planning, and make it broad-based. This will involve viewing the small family norm as an essential element of our programme of modernisation of the Indian economy and society. It should be a part of our movement for the emancipation of women, and the forces of social change should be fully mobilised, preferably through voluntary organisations. A society which has not been able to do away with the perverse custom of child marriage and the dowry system is unlikely to make a success of family planning. In other words, the social pre-conditions of family planning must be satisfied. Family planning should be intimately linked to our social security programmes. The health aspect is, no doubt, important but it cannot be the dominant aspect.

The first issue which deserves careful attention and study is the integration of family planning with health and social security under a unified *Ministry of Health, Family Planning and Social Security* both at the Centre and in each State.

In order to understand the emerging issues in the field of family planning administration, it is necessary to discuss briefly the *formulation* of the family planning programmes in the First, Second, Third and Fourth Five Year Plans.

In the *First Plan,* the problem of population growth receives attention in the very first chapter, but the advocacy of the need for population control is cautious. It said, "It is not possible to judge whether, an increasing

population is favourable or unfavourable to development.... But in the short run—and we are concerned here primarily with the earlier critical stages of development—there is no doubt that, given a situation in which shortage of capital equipment rather than of labour is the main limiting factor in development, a rapidly growing population is apt to become more a source of embarrassment than of help to a programme for raising standards of living. In other words, the higher the rate of increase of population, the larger is likely to be the effort needed to raise per capita living standards" (p. 18).

The *Second Plan* put the same idea in a more forthright manner : "The logic of facts is unmistakable and there is no doubt that under the conditions prevailing in countries like India, a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and capital equipment relatively to population as in India, the conclusion is inescapable that an effective curb on population growth is an important condition for rapid improvement in incomes and in levels of living" (p. 7).

It will be noticed that while the First Plan refers to the shortage of capital equipment, the Second Plan mentions, in addition, the shortage of land. The *Third Plan* brought into the discussion on population two more factors—the rate of saving and the growth of labour force. "In an underdeveloped economy with very little capital per person, a high rate of population growth makes it even more difficult to step up the rate of saving which, in turn, largely determines the possibility of achieving higher productivity and incomes" (p. 22). The Plan also refers to "the formidable task" of providing employment opportunities to the new entrants to the labour force.

The most important single factor which influenced the discussion on population in the Third Plan was the 1961 Census which came as a shock to the planners as the Census revealed a much higher rate of population growth than was anticipated. This gave a new orientation to the role of population control. It was not merely a question of shortage of land or capital equipment but one of "the significance of population in relation to economic development" (p. 22). The Third Plan came out with a categorical statement : "The objective of stabilising the growth of population over a reasonable period must therefore be at the very centre of planned development" (p. 25).

The *Fourth Plan* makes a plea for "a strong, purposeful Government policy." It says, "Population growth on this scale can be a crippling handicap since our population in relation to resources is already large, incomes are low and economic development is a desperate need. The speed at which a country develops depends largely upon its ability to direct a larger part of its growing resources to investment rather than current consumption. A growing population with a high proportion of dependent children

will find it increasingly difficult to do so. If population keeps growing rapidly, the major part of investment and national energy and effort may be used up for merely maintaining the existing low living standards. Population growth thus presents a very serious challenge. It calls for a nation-wide appreciation of the urgency and gravity of the situation. A strong, purposeful Government policy, supported by effective programme and adequate resources of finance, men and materials is an essential condition of success" (pp. 31-32).

To sum up, the need for population control has been emphasised on various counts in the Five Year Plans—shortage of capital equipment, shortage of land, low rate of savings, rapid increase in the labour force, a high proportion of dependent children, and the overall demands of economic growth, especially, increase in per capita income.

But interestingly enough, the philosophy of family planning put forward in these Plans does not emphasise the approach towards population control just outlined above. In other words, whereas the basic formulation of the Five Year Plans took due note of the economic consideration necessitating family planning, the advocacy of family planning in these very Plans was largely on grounds other than economic. The philosophy of family planning rested on the twin pillars of health and welfare. Welfare was understood to mean happiness. Thus the posters advocating family planning said : FAMILY PLANNING FOR HEALTH AND HAPPINESS. One cannot blame the Health Ministry for this orientation which was so very different from the economic orientation contained in the very first chapter of all the Five Year Plans. Because in all these Plans, in the chapter on Health and Family Planning, the orientation was not economic.

As the First Plan put it : "The main appeal for family planning is based on considerations of the health and welfare of the family. Family limitation or spacing of the children is necessary and desirable in order to secure a better life for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programmes" (p. 22).

The Second Plan emphasised the 'clinical' approach to family planning and set the target of opening 300 urban and 2,000 rural clinics (p. 554).

The *Third Plan* pleaded for "the integration of family planning with the normal medical and health services, specially those rendered through the primary health centres" (pp. 676-677).

There was, however, a new development towards the middle of the Third Plan period. There was a new policy orientation towards the extension education approach. As the *Draft Fourth Plan* puts it : "During the Second Plan, an action-cum-research programme was initiated. The programme was intensified towards the middle of the Third Plan when the emphasis was shifted from the clinical approach to a more vigorous extension education approach for motivating the people to accept the norm of a small

family" (p. 346). Subsequent events, however, leave one in doubt about the "vigorous" nature of the extension education approach.

The *Fourth Plan* (Final) asserts that "Family Planning finds its place in the Plan as a programme of the highest priority. Its crucial importance is reflected in the widespread public interest that has been aroused no less than in the magnitude of the effort, organisation and finance which Government is devoting to the programme" (p. 391).

Out of a proposed expenditure of Rs. 315 crores on Family Planning, the Fourth Plan provides Rs. 269 crores for the organisation of services and supplies by rural and urban centres and the compensation for sterilisation and IUCD. Thus, the programme is heavily clinic-oriented.

A detailed study of all the four Plans shows that there is a divergence within the Plans in the basic philosophy of family planning. Whereas the formulation of the Plans has been in terms of family planning as an integral part of development planning, the formulation of the programme has been in terms of family planning as an integral part of health planning. This divergence has far-reaching implications on the actual implementation of the family planning programme. The propaganda for family planning (the very first step in family planning) has been only in terms of health and welfare (understood in very general terms) and no effort was made to introduce any economic bias in terms of growing shortage of land, low rate of savings, the growing unemployment, the slow rise in per capita income, etc. Further, the emphasis on the clinical approach was responsible for the exclusion of non-clinical methods of family planning like the postponement of the age at marriage, rhythm method (only the First Plan seriously advocated it), and the withdrawal method. And the success of the clinical approach, it should have been visualised, was wholly conditioned by the success of the public health programme and in so far as there was hardly any public health programme worth the name in rural areas, the family planning programme was bound to fail.

The Third Plan nowhere said that the public health programme was at the very centre of planned development. It said that the objective of stabilising the growth of population—and by implication, the family planning programme—was "at the very centre of planned development" (p. 25). By hitching the family planning wagon to the passenger train of public health and not to the express train of development, the plan blundered and part of the blame for this must be shared by the Planning Commission.

Family planning administration is one of the newest branches of administration. It can come under the purview of both 'health administration' and 'development administration'. However, in India, ever since the first Five Year Plan pronounced family planning as "part of the public health programme", the whole field of administration of family planning programmes has been heavily oriented towards health administration. This, of course, has certain advantages in so far as there is a growing

integration between health programmes, especially MCH and family planning programmes. But there are certain disadvantages in making family planning, undoubtedly one of the most crucial national issues, an appendage of a weak ministry with a poor infrastructure. The situation cannot improve merely by constituting a separate Department in the Ministry of Health and Family Planning as was done in 1966 or by appointing a Cabinet Committee representing different ministries. The situation becomes even more unsatisfactory at the State level—and family planning like health is a State subject. As a rule, the Health Ministry is an unimportant ministry in the States and in spite of frequent pronouncements that family planning should receive top priority, there is little evidence in most States of India that family planning has in fact, received top priority. There is tendency, by and large, for the States to look upon family planning as a source of getting funds for the States and very often their eagerness to get more funds rather than their realisation of the urgency of family planning makes these States interested in family planning. This tendency is implicitly encouraged by the Central Government by *fully* underwriting the entire expenditure on family planning at the State level. As the Fourth Five Year Plan puts it : "Family Planning will remain a centrally sponsored programme for the next ten years and the entire expenditure will be met by the Central Government" (p. 393).

This is a curious situation : the entire expenditure on family planning is met by the Centre while the responsibility for implementation of the programme rests with the States. This implies, in effect, that the States will not care to take up the responsibility for funding family planning but will agree to spend whatever money is put at their disposal. *This shows the lack of commitment on the part of the States.* If this is true, it is very unlikely that family planning will succeed in India.

It can be argued, on the other hand, that it is indeed very encouraging that the States are not burdened with the responsibility of finding resources, at least in the initial stages of a national family planning programme, and they can, therefore, concentrate their energies on implementation of the programme. But it is pertinent to ask here: "Do the States have financial flexibility ? Can they modify the family planning programmes as they wish? Is there room for innovation in family planning policy keeping in mind the regional and local requirements ?"

The answers to all these questions are in the negative. We are still governed by a nineteenth century administrative set-up and the rules and regulations are not geared to the demands of rapid economic and social development. The Family Planning Department like any other Department is also subject to the standard rules and regulations of the Government of India. The second United Nations Advisory Mission which came to India to evaluate the family planning programme says in its report (1969) :

"There is rigidity in the present method by which the Central

Government allocates funds to the States. Although the funds are allocated to the States under twelve seemingly broad headings, the States are bound also to the approved schemes under these headings and even to individual items (posts, vehicles, etc.) within each scheme. Although there are variations in programme components between States, the schemes and the items within the schemes are uniformly applied within each State. This uniformity exists in spite of the great differences which obtain between States and between districts in the same State, in both the level of acceptance of family planning practices and the demand for supplies and services."

"In these circumstances, the case for uniformity rests on the assumption that it will minimize waste of human and material resources. Although this assumption may have been valid in the early years (and, in some States, perhaps still is), it is now necessary to build up management capability at State and district levels. Moreover, discretion should be granted, wherever practicable, to deviate from sanctioned schemes (for example, to authorize the States to transfer between items within a scheme, to vary the total expenditure on a scheme up to a certain percentage limit of the monetary ceiling fixed and to transfer amounts between major headings up to a certain percentage, so long as the total grant sanctioned to a State is not exceeded), in order that the programme and staffing at the various levels throughout the State can be adapted to local circumstances and requirements."[1]

There is another weakness in the Centre's approach to family planning. The Fourth Five Year Plan mentions, as we have already quoted, that the commitment of the Centre is for the next ten years, presumably upto 1979. In other words, family planning like many other departments is not on a permanent footing. One may ask again : Is it the understanding of the Central Government that the population problem of India will be solved by 1979 ? Or is it expected that the States will step in after 1979 and take up the financial responsibility for family planning ?

On the basis of demographic studies done both in India and abroad, one can say with certainty that the objective of stabilising the growth rate of population at a manageable figure will not be realised by 1979 and in fact, it may not be realised in this century. In other words, the population problem is not a transitional problem but a persistent long-term problem.

What are the implications of a "temporary" programme like family planning based on centrally financed "planned" programmes ? Again we wish to quote the U. N. Mission report :

"A serious problem in Centre-State family planning relations is the custom under which States treat centrally financed "planned"

[1] *United Nations Report No. TAO/IND/50* dated 24 November 1969, p. 21.

programmes, such as family planning, as "temporary". This causes all family planning personnel in the States who do not otherwise have permanent status to be treated as "temporary" employees. As such, they do not enjoy the rights and privileges of permanent civil servants. This practice is a handicap to recruitment and an obstacle to the development of a career service. The rationale for the practice is understandable, namely, that the States do not want to accept for all time the burden of centrally induced expenditures. The Mission, however, finds strong reasons for the Ministry of Finance to regard the family planning programme as "permanent", which would allow 80 per cent of its posts to be given permanent status. The States should be induced to adopt a similar policy, which is equally needed at that level."[2]

To sum up, the major disadvantages in the present system of family planning administration are :

(1) The programme is *entirely* financed by the Central Government, and, therefore, there is no financial commitment on the part of State governments.

(2) The States do not have the financial and administrative flexibility to modify the *national* family planning programme to meet their requirements keeping in mind the demographic, economic and social situation in their own States.

(3) The expenditure on family planning is part of the plan expenditure and the programme is *temporary* though there is a commitment on the part of the Centre for the next ten years. This hampers the recruitment of staff on a permanent basis.

(4) The family planning programme is an *appendage* of the health programme, though, in 1966, a separate Department of Family Planning was constituted under the Ministry of Health and Family Planning. And as the Health Ministry is one of the weakest and politically unimportant ministries both at the Centre and in the States, family planning is relegated to an unimportant position in spite of pronouncements to the contrary. This situation is not remedied by appointing a Cabinet Committee or a Central Family Planning Council, consisting of State Health and Family Planning Ministers. These are traditional administrative practices which cannot tackle challenging issues like family planning which call for considerable imagination and innovation in the field of administration.

We have no reason to believe that the Government of India are unaware of these handicaps in family planning administration. In fact, a Government Committee in its report in 1966 pointed out that the district was the most important unit of administration for family planning work. It emphasised that "the bulk of the work will be administrative and

[2] *United Nations Report No. TAO/IND/50* dated 24 November, 1969.

organisational, involving planning, supervision, evaluation, application of correctives, etc. Problems relating to these will predominate and not clinical problems."[3]

In other words, much of the success of family planning at the district level will depend on the administrative and organisational set-up. In spite of this realisation, the family planning programme continues to be financed, directed and controlled wholly by the Centre. In fact, it can be argued that the national family planning programme is only a Central Programme.

A recent paper (February 1971) by a high official in the Health and Family Planning Ministry points out that "The Central Government is the leader, guide, catalyst, innovator, co-ordinator and financial underwriter of the Family Planning Programme . . . It is the Central Department of Family Planning which sets the objectives and the strategy of the Programme in consultation with the Planning Commission and the Central Family Planning Council . . . There is the national Plan which is broken down into plans of the States and Union Territories. There is a centrally evolved pattern for every activity, which admits of local variations."[4]

At this stage one may ask : Is it possible to reverse this process and prepare State plans and regional plans which can be woven into a national plan ? And, if this is not possible, one may ask : Is it possible for the Centre to take note of the inter-State variations in demographic characteristics for which the censuses provide massive data ?

Soon after the main tables of the 1961 Census were published, the Institute of Economic Growth organised an all-India seminar (1964) to focus attention on the inter-State variation in population growth rates and characteristics. The papers presented at this seminar brought out the need for considering the demographic situation at the *district level* in view of the wide range of variations.[5]

The General Report of the 1961 Census of India concentrated on the levels of regional development in India.[6] It gives district-wise analysis of the level of development in the different States in India taking into account a large number of variables. Table I culled from the Census Report will give an idea of the variations.

From the point of view of family planning policy and administration,

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[3]Ministry of Health and Fimily Planning, India, *Report of the Special Committee to Review Staffing Pattern and Financial Provision Under the Family Planning Programme* (Mukherji Committee), New Delhi, 1966, p. 13.

[4]R.N. Madhok, *Management of National Programmes in Family Planning and Health*. Paper presented at the National Management Convention, New Delhi, February 13, 1971, p.2.

[5]Ashish Bose (Ed)., *Patterns of Population Change in India*, 1951-61, New Delhi, 1967.

[6]*Census of India* 1961, *Vol. I, Part I-A (i) and (ii) Levels of Regional Development in India.*

it would be worthwhile exploring the possibility of differentiation according to the four levels of development. A fresh exercise on the lines of the one done in 1961 may be undertaken in the light of the 1971 Census data and the districts regrouped again into four categories. A strategy may be evolved for each of these four categories and, instead of one standard approach, we may have a differentiated approach according to the level of development. While doing this, it is important to consider at least four factors in regard to family planning, namely, *motivation, method, men* (personnel) and *money*.[7]

TABLE I

PERCENTAGE DISTRIBUTION OF TOTAL POPULATION AMONG LEVELS OF DEVELOPMENT IN EACH STATE

	Levels of development			
	Bottom	Second	Third	Top
India	19.66	25.02	24.60	30.72
Andhra Pradesh	7.83	36.46	44.21	11.50
Assam	4.83	37.17	40.94	17.06
Bihar	32.55	45.35	8.84	13.26
Gujarat	—	12.30	45.04	42.66
Jammu & Kashmir	67.50	17.98	—	14.52
Kerala	—	10.51	79.24	10.25
Madhya Pradesh	25.77	41.27	16.68	16.28
Madras	—	—	38.59	61.41
Maharashtra	4.62	22.37	20.39	52.62
Mysore	4.67	29.99	41.87	23.47
Orissa	53.64	42.04	4.32	—
Punjab	5.33	8.77	7.57	78.33
Rajasthan	15.21	40.01	20.58	24.20
Uttar Pradesh	50.12	9.16	20.12	20.60
West Bengal	3.90	33.96	4.14	58.00

Source : *Census of India*, 1961, *Vol. I, Part I-A (i)*. p. 19.

The extent of motivation, the suitability of method, the availability of trained personnel and the allocation of financial resources will vary in the four categories of districts according to the level of development. For example, in the bottom level districts, the motivation for family plannng will be low and the emphasis has to be on propaganda to make people

[7]We discussed the role of the four M's in family planning as early as 1962 in *Seminar* (Population Control), New Delhi, May 1962.

conscious of the population problem rather than on the availability of different methods of contraception which may be the requirement of the top level districts. Similarly, the availability of personnel, especially in the medical field will vary from district to district. Perhaps the best results may be obtained by recruiting local people and not bringing in outsiders at least in programmes aimed at motivating people to accept family planning. The allocation of financial resources will raise tricky problems. Should priority be given to districts which are success-prone and where an investment in family planning is likely to make a dent on the birth rate ? Or should the money be spent on backward districts which need intensive efforts for making family planning successful ?

Another way of differentiating between districts would be to consider the rural/urban breakdown of the population. A district with a high urban proportion has a greater chance of succeeding in family planning than a predominantly rural district. The extent of motivation and the availability of health facilities will be much greater in the urban-based districts than in the purely rural districts.

Religion and community (castes and tribes) are also important factors while considering the grouping of districts. The message of family planning has to be differently worded and the approach has to be different, if we take into account peculiar characteristics of different religious groups and communities.

Finally, geographical considerations influence the attitude towards family planning. Districts in the sub-Himalayan region, border districts, islands and other special areas deserve differential treatment in regard to family planning work.

Assuming that the family planning programme will continue to be centrally planned, it is necessary to evolve a typology of districts in all the States of India, based on the following factors :

(*a*) level of economic and social development (occupation, income, literacy, etc.) ;
(*b*) urban content in the population ;
(*c*) dominance of particular religious group or community ; and
(*d*) special geographical factors.

In terms of efforts in the field of family planning, the following four important factors should be considered : (*a*) motivation ; (*b*) method ; (*c*) men ; and (*d*) money. The accompanying chart sums up the position.

The approach suggested by us is different from the present approach of selecting one or two districts in each State for intensive work in family planning, somewhat on the lines of intensive agricultural development in selected districts in each State of India. The human factor in family planning is much more intense, varied and complex than the human factor in agricultural development.

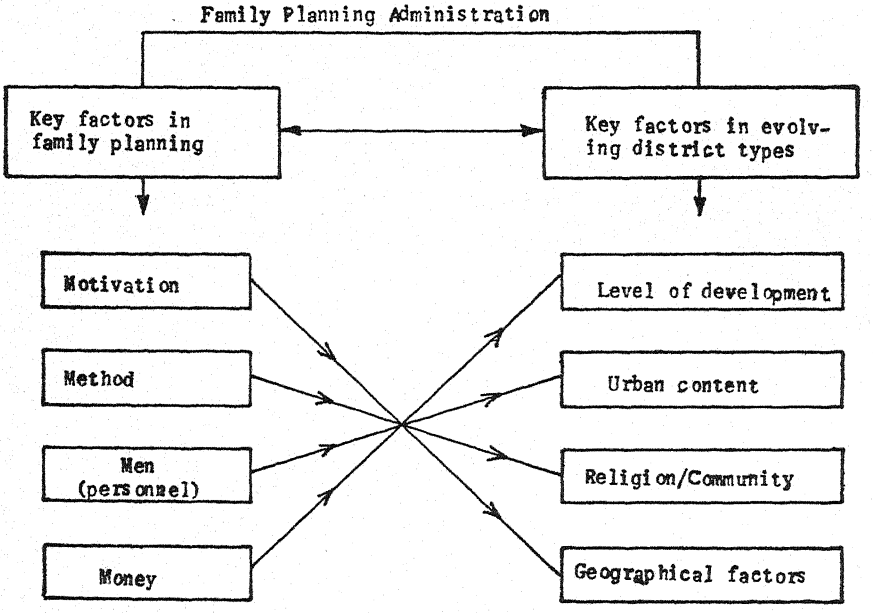
In our discussion so far, we have assumed that family planning is an

integral part of the health programme. However, it is possible to argue that the non-medical aspects of family planning outnumber the purely medical aspects as will be seen from the following :

Aspects of family planning	*Primarily medical or non-medical*
1. Motivation for a small family	non-medical
2. Banning child labour	non-medical
3. Compulsory school education	non-medical
4. Old age pension	non-medical
5. Raising the age at marriage	non-medical
6. Rhythm method	non-medical
7. Withdrawal method	non-medical
8. Conventional contraception (condoms)	non-medical
9. IUCD (loop)	medical
10. Sterilisation—male and female	medical
11. Oral pill	medical
12. Work by voluntary agencies and social workers	primarily non-medical
13. Family planning administration	primarily non-medical

In spite of the broad range of activities which should go under family planning, the implementation of the family planning programme, as we have already observed, started off with a clinical bias right from the first Five Year Plan and the extension education approach adopted in 1963 has yet to succeed. Meanwhile, the involvement of foreign agencies and foreign experts gave an alien orientation to family planning and several flippant programmes like mass mailing and the elephant project were launched. It is quite commonplace now for Indians to be told about the experience of Taiwan, Singapore and South Korea. The problem of scale is totally lost sight of in these discussions. It is an unfortunate fact that the increasing involvement of foreign experts in India's family planning programme has been, on the whole, a liability rather than an asset. U.S.A., for example, has extremely limited experience of State-sponsored family planning programmes ; the system of health services is totally different from the one in India and the role of advertisement is at a level which cannot be comprehended by the masses in India.

We should certainly welcome foreign expertise in the bio-medical field and to a limited extent, in the field of demographic research but the involvement of foreign experts in the planning and implementation of family planning work is not only uncalled for but puts family planning on the wrong track. The automatic association of family planning with health in India was perhaps influenced by Indian planners and policy-makers who were wholly dominated in their thinking by the Western experience where religion played an important role in counteracting the birth control movement. They, therefore, sought safety in the "health and happiness



approach" which in the light of events seems to be a wrong step. What prevents our planners from giving a direct economic orientation to family planning propaganda ? Why can't we tell the masses that there are too many people on land, that the burden of dependency is increasing, that there is growing unemployment and that there are not enough schools, houses and hospitals ? Instead, we harp on the theme that a small family is a *happy* family. Why this metaphysics ? Now that the Prime Minister has aroused the masses with her slogan *garibi hatao*, it is only logical that family planning is made an integral part of the overall strategy for removing poverty and is not left to health administrators alone. A beginning can be made in this direction by linking up family planning with social security.

FAMILY PLANNING PROGRAMMES AND POLICY IN INDIA

S. D. KAPOOR*

It is rather significant that a traditional culture, in which discussion of individual intimate behaviour in the public was taboo, is becoming aware of and welcoming steps for voluntary modification of individual behaviour and recognising its wider social implications. The credit for this partly goes to Sigmund Freud who, through his writings, pulled the subject of sex out of a private preserve, and the freedom of expression that obtains today and the contemporary understanding and respect for sex are largely his contributions. His thinking encouraged persons such as Charles Bradlaugh and Annie Besant as far back as 1876 to preach openly the subject of birth control even at the risk of being arrested. Marie Stopes pioneered birth control services in U. K. Later, Margaret Sanger carried the crusade for birth control in the U.S.A. and fought with officialdom in that country to provide birth control services for women. Gradually, associations of maternal and child welfare were also attracted to provide birth control services.

It was only after the Second World War that governments started taking serious notice of the population problem. It was envisaged that if development progress is to be made and economic gains achieved and consolidated, attention will have to be given to the problem of curbing population growth. Consequently, governments of developing countries increasingly started adopting or supporting family planning programmes and policies, with or without a formal population limitation policy. Though Japan passed the Eugenic Protection Law in 1948, India was the first country to launch in 1951 a nationwide official programme. This has now been followed by many countries.

Although the development of an intensive family planning programme in India is of recent origin, the movement to control birth has been advocated for more than 50 years. In 1916, Shri Pyare Kishan Wattal published his book, *The Population Problem in India.* In 1925, Professor Raghunath Dhondo Karve opened a birth control clinic in Bombay. The Neo-Malthusian League was formed in Madras a few years later. On

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June 11, 1930, the Mysore Government issued orders to open the first Government birth control clinic in the world. In 1932, the Senate of Madras University, the Government of Madras, and All-India Women's Conference in its Lucknow session supported birth control. In 1935, the National Planning Committee set up by the Indian National Congress under the chairmanship of Shri Jawaharlal Nehru supported family planning. At the invitation of the All-India Women's Conference, Mrs. Margaret Sanger visited India during 1935-36. On December 1, 1935, the Society for the Study and Promotion of Family Hygiene was formed. Dr. A. P. Pillai, a vigorous advocate for family planning conducted a training course in 1936. In 1939, "Birth Control World-Wide" opened clinics in Uttar Pradesh and Madhya Pradesh, and Col. Raina started *Matra Sewa Sangh* in Ujjain, Madhya Pradesh. In 1940, Shri P. N. Sapru successfully moved a resolution in the Council of State for the establishment of birth control clinics. About this time, Smt. Rana Dutta extensively toured India on behalf of the Family Planning Association, London. By 1940, the Society for the Study and Promotion of Family Hygiene became the Family Planning Society, incorporating the Bhagini Samaj Birth Control Clinic in Bombay. The Health Survey and Development Committee appointed in 1943 by the Government of India recommended provision of birth control services. In 1949, the Family Planning Association of India was formed under the presidentship of Shrimati Dhanvanthi Rama Rau.

A solitary instance of government action during this entire period was the very enlightened step of the Government of Mysore. On June 11, 1930, the Government of Mysore issued an order setting up birth-control clinics in the Victoria and Vani Vilas Hospitals in Bangalore and in the Krishnarajendra Hospital in Mysore. Dr. C. V. Natarajan was designated to look after this new service. Actual provision of services, however, did not continue for long.

The intellectual and political support to the family planning movement was not entirely missing during this period. The great poet, intellectual and humanist, Rabindranath Tagore supported birth-control. In a letter to Mrs. Margaret Sanger in 1925, he expressed his gratitude for her championing the cause and stated :

> "I am of opinion that the birth-control movement is a great movement, not only because it will save women from enforced and undesirable maternity, but because it will help the cause of peace by lessening the number of surplus population of a country scrambling for food and space outside its own rightful limits. In a hunger-stricken country like India, it is a cruel crime thoughtlessly to bring more children into existence that would have properly to be taken care of, causing endless suffering to them and imposing a degrading condition upon the whole family."

Justice Vepa Ramesam advocated strongly the adoption of artificial

means of birth control. The Syndicate of the University of Madras, in 1931, supported a proposal to provide instruction in contraception. In 1938, the National Planning Committee formed by the Indian National Congress under the chairmanship of Shri Jawaharlal Nehru had considered this problem at length and among other things had stated :

> "We agree with the view that the size of the Indian population is a basic issue in national economic planning, in so far as its unrestricted increase of proportion to means of subsistence affects adversely the standard of living and tends to nullify social and ameliorative measures...In the interests of social economy, family happiness and national planning, family planning and limitation of children are essential and the State should adopt a policy to encourage these. It is desirable to lay stress on self-control as well as to spread knowledge of cheap and safe methods of birth control. Birth control clinics should be established, and other necessary measures taken in this behalf and to prevent the use or advertisement of harmful methods...We consider that the raising of the marriage age and discouragement of polygamy are desirable in the interests of the limitation of the size of family...An eugenic programme should include the sterilization of persons suffering from transmissible diseases of a serious nature, such as insanity and epilepsy..."

In 1946, the Health Survey and Development Committee (popularly known as Bhore Committee) set up by the Government of India and composed of distinguished health specialists in the country recommended provision of birth control services for reasons of health of mothers and children.

The general government attitude towards birth control is reflected in the final report of the Famine Enquiry Commission, set up by the Government in 1943 after the catastrophe in Bengal. Except in the cases of Bihar and the U.P., responses to the questionnaire sent round by the Commission did not reveal any realisation of the existence of this problem, let alone a disposition on the part of provisional governments to tackle it. The Commission stated :

> "At the present time a deliberate state policy with the objective of encouraging the practice of birth control among the mass of the population is impracticable...A fall in birth rate will tend to follow rather than precede economic betterment."

This was the situation just before the country became independent, a situation in which interest in the population problem waxed and waned periodically. Interest seemed to increase with the census, visits of distinguished advocates of family planning, or publication of research reports or recommendations of enlightened individuals, groups or committees. It was only the undeterred struggle of a few individuals and groups that kept the subject from going completely into oblivion.

After Independence, epoch-making events followed one after another in quick succession in the field of population control. The Indian Army took a lead in the matter. In 1949, with the enthusiastic support of General K. M. Cariappa, Family Planning advice was included in the health and welfare scheme of the army. The programme has since taken deep roots in the defence services and is an important welfare service today.

An important landmark in this interesting history was the first All-India Conference on Family Planning, organized by the Family Planning Association of India in 1951 in Bombay. The credit for this goes to Shrimati Dhanvanthi Rama Rau and her very enthusiastic colleagues. Dr. S. Chandrasekhar, who has been drawing the attention of the public towards this problem since 1946 through his writings, presided over the Conference and gave an inspiring address. After careful and thorough deliberations, the Conference made several far-reaching and revolutionary recommendations.

The year 1951 was also the year of the decennial census in the country. The increase in population since the previous census was staggering and had a very sobering influence on the Government. Shri R. A. Gopalaswami, the Census Commissioner, in his report gave marked attention to the enormity of the increase, and the magnitude of the problem. He referred to it in the new famous phrase in "The improvident maternity."

First Five Year Plan

Almost at the same time, the Government of India which had launched on the 'great adventure' of raising the standard of living of the people through planned development was now seized of the problem. The Planning Commission which had been set up a year before had formed a panel on health programmes. This panel appointed a committee to report on population growth and family planning. Included in this committee were Shri R. A. Gopalaswami, Shrimati Dhanvanthi Rama Rau, Dr. Gyan Chand, Dr. A. C. Basu and Dr. Sushila Nayar, who later became the Minister for Health. On the basis of the recommendations made by this panel and the untiring efforts of Shrimati Durgabai Deshmukh who was then Member of the Planning Commission, family planning was included as a welfare programme in the First Five Year Plan and an allocation of 6.5 million rupees was made—the first ever made by a national government in the world.

The same year, the Government of India obtained through the World Health Organisation the assistance of Dr. Abraham Stone in setting up and conducting pilot studies on the rhythm method. Though many family planning workers were critical of his advocacy of the rhythm method, in view of the fact that this was the first venture of a national government in this field and that his visit was made possible by WHO, Dr. Stone's visit must be considered an event of great historical importance. Travelling

widely throughout the country, Dr. Stone drew public attention to the need for controlling births. As a result of his visit, two experimental centres, one in the north, Lodi Colony in Delhi and the other in Ramanagaram in Mysore State, were established to conduct studies on the rhythm method, which, were the forerunners of many research centres to be established and studies to be conducted in the country in the years to come.

The Family Planning Research and Programme Committee was appointed in 1953 with Major-General C. K. Lakshmanan as its Chairman and Dr. C. G. Pandit and later Dr. T. Lakshminarayana as its Secretary. It included distinguished doctors of medicine and public health experts, demographers and social scientists in the country. The Committee made important recommendations on the scope of family planning, location of centres, staff and accommodation, training, and field studies and research. In regard to methods of contraception, the Committee advocated the rhythm and the diaphragm and jelly. Despite strong advocacy for giving support to sterilization schemes and the rising numbers of cases in hospitals, the Committee under the presidency of Rajkumari Amrit Kaur, the then Health Minister felt necessary to defer the scheme and to collect basic information.

Dr. Marie Stopes had in the meantime advocated the use of cotton pad and oil as a suitable method for India. Shrimati Shukuntala Paranjpe who had endorsed its use because of its being inexpensive, later became an ardent supporter of sterilization.

Thus, in the early days of the programme, the methods recommended were the rhythm, diaphragm and jelly and later foam tablets. These were provided through family planning clinics, the number of which rose from 50 in 1951 to 165 in 1956.

Dr. Sushila Gore was appointed as a Special Officer in charge of training. She led a touring team and trained a large number of family planning workers. Later, in 1957, she organized the Government of India Family Planning Training and Research Centre in Bombay.

Research, largely medical, was undertaken by several institutions in the country with financial assistance from the Central Government.

Against an allocation of 6.5 million rupees, the expenditure during the First Five Year Plan period was only 1.45 million rupees.

Second Five Year Plan

At this stage, the Planning Commission recommended the strengthening of the central organisation for family planning and augmenting the scope of the programme. A Central Family Planning Board was formed. Lt. Colonel B. L. Raina was appointed as an Officer on Special Duty on September 26, 1956 and later designated as Director, Family Planning.

From 1957, the programme developed further under the stewardship of Shri D. P. Karmarkar, who had taken over as the Health Minister in the

reconstituted Cabinet after the second general elections. The programme had now four clearly identifiable components— *education, service, training* and *research.* Major activities included development and strengthening of the administrative machinery at the Centre and in the States, liberalised and flexible assistance to voluntary organizations and local bodies, extension of the training programme, inclusion of family planning in the medical curriculum, people's participation in the programme, follow-up, support for sterilization schemes, research and measures to produce contraceptives within the country.

By the end of the Second Five Year Plan, there were 4,135 clinics. Sterilization which had been pursued vigorously in Madras State was included in the programme of the Government of India in 1958 and central assistance for sterilization schemes made available from 1960. By the end of the plan period, more than 150,000 sterilization operations had been performed. Widespread awareness of family planning was created in the country through the production and distribution of large quantities of informational material. Using well-planned scientific surveys much valuable information was collected. There was evidence that, where there were adequate inputs, the birth rate could be lowered.

Research took long strides during this period. Medical research was coordinated by the Reproductive Biology Committee of the Indian Council of Medical Research with Dr. V. R. Khanolkar as Chairman, communication action research by the Communication Action Research Committee with Professor P. C. Mahalanobis as Chairman and demographic research by the Demographic Advisory Committee with Professor V. K. R. V. Rao as Chairman. These committees were able to place research activities on a firm base. International agencies, specially the Population Council and the Ford Foundation gave valuable support to research activities.

The Mysore Population Study conducted in 1951-52 under the joint auspices of the United Nations and the Government of India and Mysore was published during this period and can be considered as a first methodological study undertaken in this direction. It yielded much valuable information on the population of Mysore State. The National Sample Survey Organisation collected a great deal of information for the entire country in its several rounds.

In 1957, the Demographic Training and Research Centre was established in Bombay as a joint effort of the United Nations, the Government of India and the Sir Dorabjee Tata Trust. Communication action and demographic research centres had been established or were in the process of being established all over the country. The research in these centres was providing useful leads.

The expenditure during the Second Plan period was to be about Rupees 21.56 million, fifteen times more than the First Plan expenditure.

THIRD FIVE YEAR PLAN

The Committee for the Third Five Year Plan reviewed the experience that had been gathered in the preceding ten years. Since this period, there have been two distinct trends in the progress of the programme. After the third general elections, Dr. Sushila Nayar became the Health Minister and she laid great emphasis on providing family planning services through all medical and health centres, and strengthening of the basic health services. The State Governments were also advised accordingly.

The second guiding factor emerged from a critical review of the programme carried out by the Director, Family Planning. On the basis of performance in the field and findings from research studies, the Director recommended two major shifts in the emphasis in the programme. One of these was to make it a community-centered programme rather than a clinic-centered one and the second was to involve to a greater extent the man in the programme. The revised programme was named as the "Extended Family Planning Programme" and it was discussed in a special workshop convened for the purpose in September 1963. The Government of India accepted it and the order for its implementation was issued on October 4, 1963. Thus the year 1963 was the turning point in the national programme. The main components of the extended programme were : (1) creation of a social climate in which the need is felt by individual families and by groups of people ; (2) knowledge that a small family norm is valuable to each individual permeating into every mind ; (3) provision of readily accessible services, generally, as a part of health services especially health of mothers and children ; (4) adoption of effective methods by all eligible couples ; (5) stimulation of social changes affecting fertility such as education and employment of women, increasing age at marriage, etc.; (6) research with emphasis on action research and feed back mechanisms to use the findings in programme operations ; and (7) evaluation. The organization for the programme was modified accordingly with ramifications right down to a population unit of 10,000 in the rural areas, and with units for work in the urban areas.

The year 1965 is of great importance for two reasons—the Indian Council of Medical Research cleared the intra-uterine contraceptive device for mass use on January 5, 1965 after extensive trials in the preceding two years and it was included in the programme in July, the same year. The other was the visit of the United Nations Evaluation Mission led by Sir Colville Deverell, the then Secretary-General of the International Planned Parenthood Federation. Another notable event was the appointment of the Family Planning Programme Planning and Evaluation Committee by the Government of India. Both these teams toured the country extensively, interviewed family planning workers and visited training centres and research institutions. Both recommended considerable strengthening

of the organisation, stepping up of training activities and improving evaluation.

As a consequence, the organisation at the Centre at the policy-making level as well as at the decision-making one, was greatly strengthened. Its full implementation actually started in 1966.

During the Third Plan period, research was making steady progress at 22 centres—seven demographic research centres, seven communication action research centres and eight centres conducting studies on bio-medical aspects—established all over the country.

With a view to developing a multi-disciplinary agency that would serve as a technical resource to the national family planning programme, the Family Planning Institute was established by amalgamating six units functioning under the Directorate-General of Health Services in Delhi in October 1962 as a Government institution. Later, realizing that, for the development of research and training, the intellectual climate should be permissive and conducive to the growth of new ideas and free exchange of thought, the Institute was declared as autonomous in March 1965 and was redesignated as the Central Family Planning Institute with full support from the Government. Since then, the Institute has developed rapidly. Besides other activities, the Institute acts as the Secretariat for the Demographic and Communication Action Research Committee.

At the end of the Third Plan, there were 3,676 rural family welfare planning centres, 7,081 rural sub-centres and 1,381 urban family welfare planning centres providing supply services and advice on family planning to needy couples all over the country. Twenty-eight regional family planning training centres had also been established during this period. A factory for producing loops and inserters was established at Kanpur. The number of sterilization operations had gone up considerably; 1.37 million operations were performed as compared to 0.15 million in the earlier plan period.

The programme had achieved enormous success but not to the extent expected. The expenditure on the programme was 248.6 million rupees against a provision of 270 million rupees and with a ceiling of 500 million rupees. During the same period, we had to face two wars with our neighbours and to a certain extent they gave a set-back to the programme for some time.

At the end of the Third Plan period, the birth rate stood around 41 per thousand. Successful public health and curative measures had brought down the death rate to around 16. Thus the growth rate touched a high figure of 25 per thousand. This made the Government of India think hard and implement the programme vigorously.

Family Planning Programme Since 1966

As a result of rethinking on the part of the Government of India, the

family planning programme has gained much momentum since 1966. To start with, a Cabinet Committee of five Union Ministers was designated as the agency for evolving policy. For about two years, the Prime Minister herself had taken over the leadership of this Committee. Now it is headed by the Union Finance Minister, Shri Y. B. Chavan. A Central Family Planning Council, which includes all the State Ministers for health and family planning, representatives of voluntary organisations, institutions and some distinguished individuals and presided over by the Union Minister for Health and Family Planning, serves as an advisory body to this committee and coordinates the programme all over the country.

On the executive side, a Department of Family Planning was established in April 1966 within the Ministry of Health and Family Planning. The department has two wings—the secretarial wing headed by a Joint Secretary and the technical wing headed by the Commissioner for Family Planning and Maternal and Child Health. Since reorganisation, both the wings have been considerably strengthened. Six regional offices at Ahmedabad, Bangalore, Bhopal, Calcutta, Chandigarh and Lucknow, each with a regional director at its head maintain liaison between the Central and State Governments.

At the ministerial level, two notable changes took place in 1967. Dr. S. Chandrasekhar who has been associated with studies in population problem and family planning for a number of years both in India and abroad was appointed as the Minister of State for Health and Family Planning in March, 1967. In November the same year, the stewardship of health and family planning was elevated to cabinet rank and Shri Satya Narayan Sinha was appointed the Union Minister for Health, Family Planning and Urban Development.

The programme was geared towards bringing about change in attitude and behaviour with the guiding principles to convince individuals that the change is in their interest, that it is socially accepted and that it is desirable and is approved by their peers. The *Cafeteria Approach* which means making available a variety of scientifically proved and tested methods of contraception so that the couples could pick and choose the one best suited to their requirements, was made the main plank for the provision of contraceptive services to the 100 million eligible couples in the reproductive age-group. This met with an immediate success. Within a period of two years, the number of acceptors had been nearly doubled, registering a record figure of three million in 1967-68. Next year, the number increased to 3.1 million. The sterilization figures rose steadily during this period and about 4.4 million operations were performed. During this period, about 2.1 million IUCD insertions were done. The distribution of Nirodh was stepped up as it was felt that probably this was the most widely used method of contraception. An organization for Nirodh marketing programme was set up on the experience gained in a study to promote the sales of condoms

through existing commercial channels conducted by the Central Family Planning Institute in Meerut district within the Department of Family Planning and it undertakes the marketing with the cooperation of six leading commercial organisations throughout the country. The first phase of a massive continuous advertising and sales promotion programme was launched in selected areas on September 25, 1968. Local production of condoms, which had been encouraged during the Second and Third Plans, was not able to cope with the demand. As a result, the Government of India floated a public undertaking, the Hindustan Latex Limited, and the factory was established in Trivandrum, Kerala, with an initial production capacity of 144 million pieces every year.

Another notable feature of this period was the mounting of a massive programme of mass education and motivation. An abstract symbol, the inverted red triangle, was adopted to take the message of family planning to every home. This symbol can now be seen in almost every nook and corner of the country. Not only this—many other countries have also adopted the inverted red triangle as the symbol of family planning in their own countries.

Fourth Five Year Plan

On the eve of the Fourth Plan, five central training institutions and 43 regional family planning training centres were functioning and were preparing to train 10,000 medical and 150,000 para-medical personnel required to implement the programme vigorously. There were 4,326 rural family welfare planning centres, 22,826 rural sub-centres and 1,797 urban family welfare planning centres in operation.

It has been stated in the Fourth Plan :

> "Family planning will remain a centrally sponsored programme for the next ten years and the entire expenditure will be met by the Central Government. It will be ensured that performance does not lag behind the expenditure. The effort will be to achieve enduring results through appropriate education and motivation. General health services will be fully involved in the programme."

The Fourth Five Year Plan outline referred to family planning as 'the kingpin of the Plan' and 'limitation of family as an essential and inescapable ingredient of development. The high priority given to family planning was reflected in the formation of a Cabinet Committee with the Prime Minister, Shrimati Indira Gandhi as the Chairman. Similar Committees have been established in most States. A Department of Family Planning was formed within the Ministry of Health and Family Planning. Currently, a Cabinet Minister is in overall charge, with a Minister of State guiding the programme, and a Secretary to the Government of India exercising administrative control. The expenditure on family planning has risen

steeply from 1.45 million rupees during 1951-1956 to 65.3 millions in 1967-1968 and to an estimated 370 millions in 1968-69. A massive provision of Rs. 3,000 million has been made for the Fourth Plan (1969-74).

The objective of the programme is to reduce the present growth rate of 2.5 per cent per annum to about half by 1978-1979. This is based on an assumed course of mortality starting with an initial expectation of life at birth of 41.9 years for males and 40.6 for females centered in 1956, an increase of 0.9 year every year till 1970 and 0.75 per year thereafter. Under these mortality assumptions, the birth rate is expected to be reduced to 23 per 1000 by 1978-79.

The Indian system of government is federal in character. Consensus on all matters relating to national development among the federating units is achieved through the National Development Council of which the Prime Minister is the Chairman and the State Chief Ministers are members. For purposes of evolving policy in the area of family planning, there is a Central Family Planning Council with the Union Minister for Health and Family Planning and Works Housing and Urban Development as Chairman and the State Health Ministers as members. Similar councils function at the State level.

Some of the policy matters which have been considered in the course of the development of the family planning programme were :

(1) Should there be an element of compulsion ?
(2) Is medical background a necessary qualification for the top leadership ?
(3) Should a family planning programme be conducted exclusively or primarily by the health department ?
(4) Are there advantages to be gained by using multi-purpose workers ?
(5) What is an appropriate combination of social scientists, medical personnel and administrators in the staffing of a family planning programme ?
(6) Should monetary incentives be given ?
(7) Should the training of workers be entirely job-oriented ?
(8) Should the rural areas with their greater population be tackled first, or should the critical targets be those which are considered to be more receptive to new ideas ?
(9) Should a family planning programme concentrate its manpower resources and services in a few places where the probabilities of success are greater ?
(10) What is the relative emphasis to be given to the utilization of mass media vis-a-vis carrying out face-to-face education by health educators and field workers ?
(11) Should the scope of family planning be limited to the quantitative aspect (control of births) or should it be extended to the qualitative aspects too ?

(12) Should time and energy be expended on the possibility of developing social policy and legislative measures that might be conducive to the curtailment of family size ?

The programme developed as an integral part of the existing medical and health services. It was felt that, so long as contraceptive methods offered require the services of medical and health personnel, implementation of the programme should be through the health services. The integration of family planning with maternal and child health services has strengthened the programme by capitalizing on the skills of the workers at every level and by the fact that these workers are already accepted by the community. If medical and health personnel in the integrated programme tend to dilute the effort required for family planning, the remedy lies in educating these persons to involve themselves more in the programme so that the limitless opportunities available in the antenatal, post-natal and pediatric clinics are utilized fully, and in strengthening the basic health services. The focus is on interdisciplinary collaboration.

Service centres are called family welfare planning centres. All effective and safe methods are made available, the individual having the freedom of choice of the method. Emphasis, however, is laid on sterilisation, IUCD and condoms. A scheme for the highly subsidized sale of condoms through normal trade channels was launched in 1969. Large scale field trials on pills are in progress. Services are provided as close to the people as possible.

The programme is flexible and is based on action research. The Demographic Communication Action Research Committee reviews current research in demography and communication and indicates further lines of work. The Central Family Planning Institute,* a multi-disciplinary institution, coordinates the work in these fields and conducts methodological and diagnostic studies. Bio-medical research is guided by the Indian Council of Medical Research.

The programme in India is an entirely voluntary one. The Government of India, however, has a scheme for compensating persons undergoing sterilization or an IUCD insertion for any loss of wages and other incidental expenditure they may incur. Monetary incentives, at best, are considered as temporary expedients and educating the community the method to yield lasting results. Investment in extension education techniques should be appreciable. Identification of local leaders, training them, and using them as channels for extending the programme and serving as a vital link between households and service-giving agencies has already given encouraging results.

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*Now, National Institute of Family Planning.

X FUTURE TRENDS

Experience of the past few years of the implementation of our programme has shown that an integrated approach comprising Health, Family Planning and Maternity-cum-child Health components can best project its image as being a programme for the welfare of the individual and the families. Practical demonstration of ensuring health and care of the mothers and the children through immunization and nutrition programmes will convince the people of the survival of the children that are born and strengthen their faith in the norm of a small family. We have, therefore, to bend our energies in hastening this process of integration.

The solution of the population problem calls for a programme of a long-term character. Its success will depend upon sustained efforts and the building up of a network of minimal infrastructure for the delivery of services all over the country, coupled with intensive efforts in populous districts, organised sector of employment and hospitals where there are a large number of maternity cases. The government is determined to give highest priority to the provision of a Primary Health Centre for a unit of about 1,00,000 population and a sub-centre for a unit of 10,000 population.

Fears are often expressed that family planning is confined largely to urban areas and, there too, it is resorted to by the well-to-do and educated families. It is also said that contraception is practised by the majority community and some minority communities try to keep away from it. The point made is that the family planning, as it is considered now, would give rise to serious imbalances in the quality and texture of the population's composition. These fears are not warranted either by the facts or experience. Nearly two-thirds of the contribution to family planning comes from rural areas where 75per cent of the population is illiterate and the services cannot reach large tracts inhabited by one-third of the rural population. The response of the rural folk in the face of these handicaps is truly encouraging. Evaluation of the work in cities like Bombay shows that given the correct efforts, the participation of dwellers in hutments too would not lag behind that of the well-to-do sections of the community.

A heartening feature which has been recognised all round and was also noticed by the U. N. Mission is the absence of any organised religious opposition to the programme and its concepts. There are pockets here and there, of short-term resistance which are overcome by the enlightened opinion and down-to-earth commonsense of our people. Nevertheless, we have to be ready with adequate information and manpower to counter such resistance and we should be able to anticipate the places and occasions where it is likely to be generated. This is an area for fruitful activity by the voluntary sector.

A people's programme like family planning cannot succeed without a massive and effective involvement of voluntary agencies and social workers

all over the country. Understanding, warmth, courtesy and consideration are necessary in dealing with voluntary organisations and social workers for winning them over for team work in this national effort. The government are conscious that more articulate steps have to be taken to bring more fully into the fold of this programme organisations of all-India character, like the Family Planning Association of India, Indian Red Cross Society, FICCI, UPASI, and the various Universities.

Over 40 per cent of our population consists of 0-14 age-group which will continuously enter the reproductive span. If the population problem is to be contained for the future, this group should be properly 'indoctrinated' at this stage, through population education in the schools, colleges, teacher's training courses, and adult literacy classes. Specialised campaigns will also be needed amongst those in this group, who do not get opportunity to go to the schools. This is a vast—and as yet uncharted—area for the voluntary sector to make a signal contribution of a lasting nature to the solution of the population problem.

Among further population policy measures contemplated, the major ones are increasing the age of marriage and liberalisation of abortion. The estimated mean age at marriage for females during each of the six inter-censal decades starting with 1891 was 12.8, 13.8, 13.5, 12.5, 14.9 and 15.4 years. The State Act (the Child Marriages Restraint Act) enacted in 1930 and subsequently amended in 1949 and in 1956 raised the age at marriage for girls from 14 to 15 years and then to 16 years. The present age at marriage is estimated to be about 16 years, and varies in different States. One could expect that an increase in the age at marriage would reduce the reproductive span and thus affect fertility. However, it is difficult to estimate the actual reduction in fertility occurring from a specified increase in age at marriage without knowing what changes might occur in the family-building process on account of such an increase. A study carried out by the Registrar-General of India in 1961, on rural and urban samples in four selected States showed an association between postponement of marriage and reduction in the number of children born. Several other studies claim different degrees of reduction in the birth rate (12 to 50 per cent) if the age at marriage is increased to 20 years. It is obvious that if a girl marries at a later age than at present she can have a chance of education and perhaps employment, and will be more mature; therefore, it is likely that she will adopt a more positive and rational attitude towards family size and child birth and will accept family planning quite early in married life. Attempts are being made with the help of social welfare organizations to create a social climate favourable to girls marrying at a later age than at present. Legal measures for increasing the age at marriage are also under consideration.

Performing an abortion is legal in India only for the purpose of "saving the life of the woman". It is difficult to estimate the incidence of abortion

in the country. It is estimated that annually there may be over six million abortions in the country. The Ministry of Health appointed a committee to study the possibilities of legalizing abortions. The committee considered that the present legal provisions are too restrictive and recommended, among other things, that the provision for abortions should be liberalized to allow for the termination of pregnancy by a qualified medical practitioner, not only for saving the pregnant women's life but also when the continuance of the pregnancy is likely to affect the woman's health either before or after child birth. It has also been suggested that the woman or her husband should be persuaded to undergo voluntary sterilization to ward off the danger of repeated abortions and further pregnancies except when the medical practitioner does not consider it necessary. The Central Family Planning Council considered the report and made further suggestions and amendments, but the basic recommendations were not changed. A draft bill for liberalizing the abortion law is already under consideration by the Parliament.

Statutorily, widow re-marriage is allowed now. The effect on fertility will depend on the magnitude of increase in widow re-marriage and the age at which they re-marry, but it is a factor which will increase fertility.

The Employment of Children Act, 1938 and the Factories Act, 1948 and later amendments to them prohibit employment of children below 14 years of age, and their employment at night and in dangerous occupations. The law is limited in its scope in the sense that it does not apply to rural areas. In agricultural communities, the number of children seem to be considered as a source of economic return (free farm labour) although these children generally are at near-subsistence level or even below it. Measures to remove children from the labour market will strengthen fertility-control. A study on social change in three groups, pre-industrial, partially industrial, and industrial, showed that all the three groups were 'worried about education of children' and wanted their children to have a better standard of living and were in favour of technology (rural groups were more in favour). This is an encouraging trend. Extension of educational facilities and compulsory school education will be measures in the desired direction. It has been stated that primary education is a 'vital sector' not only for economic development, but "even in the matter of achieving the small family norm'.

Education of girls is of special significance. It is estimated that while 90 to 95 per cent of the boys are attending elementary schools, hardly 60 per cent of the girls go to school. The 1961 census shows that female literacy in India ranged from 11 to 47 per cent. There seems to be a definite correlation between education and fertility. The NSS 16th round has shown that the number of children born per woman was two if she had passed the intermediate examination (that is, two years in a university), 4.6 if she was a matriculate, 5.0 if she had middle school education, and 6.6 if illiterate or of primary school education.

Statutory provisions for maternity benefit to women workers are regulated under a number of State Acts and several Central Acts—Plantation Labour Act, 1951, the Employees' State Insurance Act, 1948, the Employees' State Insurance (Amendment) Act, 1966, and the Maternity Benefit Act, 1961. Maternity leave is granted to non-industrial employees of the Government of India through specific provisions in government rules. The Maternity Benefit Act, 1961, among other benefits, provides for the payment by an employer of the average daily wage for the period of actual absence immediately following the birth of the child the maximum period being restricted to 12 weeks. Some State Governments have limited the grant of maternity benefit to their non-industrial employees to three children.

The present focus is on reduction of births or 'family limitation' and will have to remain so for some time to come. The perspective of family planning should, however, include measures for the total welfare of the family which would comprise spacing, treatment of infertility, family life education, marriage guidance including genetic counselling, prevention and treatment of hereditary disorders and the associated area of child care. When communicable diseases are wiped out by the mass programmes, when morbidity from the common diseases is reduced considerably by improved environmental sanitation, when expectancy of life is increased substantially by promotional measures, derangements and diseases of genetic origin will become preponderent. Frequency of such abnormalities are well known in Europe and America. A survey of school children in London 20 years ago showed that 65 per cent of blindness was due to environmental causes such as infection, whereas another survey conducted recently revealed that blindness in 65 per cent was genetic in origin.

Various measures such as land and taxation policy will need examination. Division of large holdings into smaller ones, land tenure credit system, peasant proprietorship, legislation concerning inheritance, and security in old age may have an appreciable bearing on fertility behaviour. Unemployment insurance and old age pension are being considered; in fact, some States have already introduced old age pension to certain categories of persons.

The Small Family Norm Committee of the Government of India has made several recommendations with regard to future policy. Since maternity benefits for industrial workers are associated with many problems, no change has been suggested for the present. A bonus of a month's salary is suggested for those women workers who get themselves sterilized after the second child. Special facilities for health, welfare and other social services may be considered for children of persons who undergo sterilization after two or three children. Income tax chargeable from bachelors should be the same as that from married persons. Rebates should be allowed to those having upto three children, but for those who have more than three, the rebate allowable should be the same as that for a married person without a child.

The Life Insurance Corporation of India should introduce a new kind of policy redeemable 18 years after marriage and carrying special benefits for those who have limited the family to one, two or three children. Family planning education should be included in the curricula of educational institutions. All agencies should encourage their employees and persons within their sphere of influence to have small families. Efforts made in this direction should be recognized suitably.

There is no doubt that higher agricultural production, development of an efficient transport system, expansion of public health and medical facilities, and improved civil administration tend to reduce mortality. Industrialization in its wake brings about changes in the value system but the hard core values take time to change. Education—especially of women, emancipation of women, an increasing level of aspirations, a better purchasing capacity, easy availability of consumer goods at cheap rates tend to bring about change in values. Improvement of production in agriculture and industry, and development of consumer goods and small scale Industries are efforts which will have the desired effect in this direction. It is hoped that local leadership which is being developed through the process of democratic decentralization in the *Panchayats* will bring about new values.

It is known that changing fertility behaviour is a complex process. It has to be dealt with in the broad perspective of social and economic changes and should have a multifactorial approach. There is no single magical step that will solve the whole problem. The criticism that one or the other type of social policy change will not 'do the whole job' and if at all effective, will take time, is not valid. A number of apparently unrelated steps have to be taken which, cumulatively, will bring about a favourable climate in which the small family norm will be considered socially acceptable. The process of establishing the small family norm can be speeded up, if the approach to child-bearing is made more rational and objective, and the powerful forces of education, extension education, social policy and social legislation which condition human behaviour are harnessed fully.

We also must continue to seek much better basic understanding of human biology and behaviour as they relate to reproduction. It is obvious that, although we have gone far in learning how to build practical family planning programmes, our basic knowledge is still relatively scanty. The problems of adjusting reproduction to resources will be with us for a long time, and it behoves us to gain better scientific understanding of this area. The fact that profound changes are occurring and will be occurring henceforth gives an excellent opportunity to learn, at the same time, about the dynamics of such changes, in different groups and under different situations.

In the present programme, there is still great need for administrative and operational research at all levels, to clarify organisational problems and to find solutions for these. The solutions to these problems will

inevitably lead also, to development of a stronger base for future health programmes. Efforts in these directions can lead to the achievement of the World Health Organisation objective "to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment".

We are dealing with a problem which dominates our time, underlying much of the world's political unrest, and frustrating man's hopes for better life. It certainly deserves our most devoted and most imaginative efforts, on a most urgent basis. As we strive to meet the immediate crisis which is a quantitative one, it is well to think now, also, about the ultimate, qualitative good of raising the level of daily living of mankind, of further freeing and raising the quality of the human mind. We should be starting to study more carefully the inevitable genetic efforts of rapid demographic transition, on selection of human traits, including psychological traits, especially the capacity for abstract thought. And we should maintain a strong concern for building the social and cultural environment which preserves and promotes the dignity of individuals. As we work on such common problems, we hope that the spirit of world neighbourliness and international goodwill can also flourish.

With the harnessing of all available knowledge, skill and experience, humanity can gain control over its fertility. If we proceed with objectivity, cogency and humility, the stage is set for such control and perhaps for moving beyond to levels of human civilization and concord, not yet

FAMILY PLANNING POLICY AND ADMINISTRATION : AN OVERVIEW

DR. K. N. RAO*

"We believe that the population problem must be recognised as a principal element in the long range national planning, if governments are to achieve their economic goals and fulfil the aspirations of their people.

"We believe that the majority of the parents desire to have the knowledge and the means to plan their families; that the opportunity to decide the number and spacing of children is a basic human right.

"We believe that lasting and meaningful peace will depend to a considerable measure upon how the challenge of population growth is met.

"We believe the objective of family planning is the enrichment of human life, not its restriction; that family planning, by assuming greater opportunity to each person, frees man to attain his individual dignity and reach his full potential.

"Recognising that family planning is the vital interest of both the Nation and the family; we, the undersigned earnestly hope that leaders around the world will share our views and join with us in meeting the great challenge for the well being and happiness of our people every where." (Declaration on population growth, and human dignity and welfare by Heads of Governments on Human Rights Day, 1967).

The world is faced with many problems. Amongst them five stand out as moral imperatives for attention. Poverty, hunger, disease, war and population explosion. As the last leads to the other four, it has priority for action. The world population which is 3.6 billion is currently growing at 2 per cent per year. For the developing region, the problem is essentially one of growing numbers that are hindering economic development plans and frustrating the aspirations of the people for a better way of life. The developed countries have also population problems concerning urbanization, population distribution and the integration of the under-privileged into the dominant socio-economic structure of the society. The World Health Organisation in the preamble to the constitution defined health as a state of well-being, physical, mental and social and not merely the absence of disease or infirmity. Though this ideal has not been attained by

*Secretary-General, Population Council of India.

any nation so far, the levels of health of the nations, states, human groups and families vary markedly depending on their numbers and adequacy of resources. With the resources being limited, the well-being of a population group in a nation, state or family is inversely proportional to their numbers.

India's Population Problem

India's population is 547 millions (1971) with only 2.4 per cent of the world total area and 2 per cent of the total world income, to support 14 per cent of the world total population. There are about 21 million births and about 8 million deaths a year adding 13 to 14 million to the existing population every year. While the birth rates are remaining around 40, the death rates are around 15-20 per 1,000 population giving a growth rate of about 2.5 per cent. At the current rate of increase, it may double itself before the end of the century reaching the incredible figure of more than one billion.

Population, as a problem, has been engaging the attention of social scientists from 1916. A Family Planning Clinic was established by the Government of Mysore in 1936. In 1938, the National Planning Committee of the Indian National Congress under Sri Jawaharlal Nehru observed that the size of the Indian population was a basic issue in National Economic Planning. The Health Survey and Development Committee (Bhore Committee) in 1946 drew the attention of the Government to the population problem.

India is now as the only South Asian country, and the only major country in the world that has a public policy aimed at reducing fertility through the spread of birth control, among the masses of people and has adopted a family planning policy in the health sector as an integral part of its development plans since 1952. The allotments for family planning were : First Plan (1951-56) Rs. 6.5 million (expenditure, Rs. 1.6 million); Second Plan (1956-61) Rs. 50 million (expenditure, Rs. 23 million); Third Plan (1961-66) Rs. 270 million (expenditure, Rs. 133 million). In the Fourth Plan, Rs. 3,000 million are provided. It may thus be seen that the programme at no time suffered from lack of provision of funds. As in any other development programme, the health and family planning programme should have a sound organisation.

In India, the organisation of health administration is governed by the distribution of responsibility between the Centre and the States. The Centre is largely responsible for the central and concurrent lists. International relations, Coordination of activities, Planning, Technical Education etc., are to a large extent the responsibility of the Central Government. Health and Education have been under the state sphere even before the advent of Independence. With the introduction of economic planning and the establishment of the Central Council of Health in 1952, a good deal of

coordination is effected. As health is indivisible and knows no geographical boundaries, the programme connected with the nation's health calls for a concerted and unified approach. However, while the Central Government plans, coordinates and lays down policies, the implementation of the programme lies largely in the State's sphere.

In the economic planning, there is still emphasis on physical investment and there is need for the realization that investment in human resources—health and education—is vital to development.

Administrative Organisation

At the Centre : The Cabinet Committee, with the Prime Minister as Chairman, and consisting of the Union Minister for Health and Family Planning, Ministers of State, Finance, Social Welfare and Health and Family Planning as members periodically review and lay down policies for action (Chart I). The Ministry of Health and Family Planning is assisted by the Central Family Planning Council which has been established on the lines of the Central Health Council with the State Health Ministers and representatives of All-India Organisations and other departments concerned with family planning work as members under the chairmanship of the Union Health Minister. The Central Family Planning Institute, the Demographic Communication Action Research Committee, and the Bio-medical Research Centre function as scientific and expert bodies. The Union Minister has three departments : (1) Department of Health, (2) Department of Family Planning and (3) Department of Works, Housing and Urban Development. The Cabinet Minister is in overall charge with Ministers of State or Deputy Ministers in charge of the respective departments.

At the Secretarial level (Chart II) for the development of family planing, the Joint Secretary is solely responsible to the Secretary. The Commissioner, Family Planning who is in charge of programme implementation, and the Marketing Executive (Chart II and III) are responsible to the Joint Secretary who is in charge of Planning, Programme, Coordination and Administration (Chart IV). The Commissioner, Family Planning is assisted by three Deputy Directors for progress and services, training, technical operation and by the Chief of Media (mass communication) and their staff. There are six Regional Directors of Family Planning, located in six regions of the country for coordinating work with the State Governments. An Executive Board under the chairmanship of the Secretary with Joint Secretary, Family Planning, Joint Secretary, Finance and Commissioner, Family Planning as members, expedites clearance of new schemes.

Functions of the Department

The Department of Family Planning has become the planner and financial controller of the total operation. Production, supply and transport

functions are also performed by the department. Mass communication is another vital function. Direct operation of the programme for the 10 million Central Government employees and families, the programme of the Union Territories and Nirodh making are some of the other functions.

State level : The State Cabinet Committee (Chart VII) with the Chief Minister as the Chairman, and consisting of Ministers of Health, Finance and Welfare as members reviews and lays down policies for implementation of the programme. The Department of Health is assisted by the State Family Planning Council or Board and the Action/Implementation Committee. The Director of Health Services who is in charge of the programme is assisted by the Additional/Joint or Deputy Director in actual implementation. The Bureau is assisted by a grants committee. All the programmes within the State except the post mortum programme are managed by the State. The States can propose experimental projects to try innovations.

District level : The District Organisation (Chart VIII) is headed by the District Family Planning Officer with an attached bureau and assisted by an Implementation Committee. The District bureau is charged with the function of supervising voluntary organisations also.

Block level : The Senior Medical Officer or Medical Officer at the Primary Health Centre heads the organisations at the block level, supervises and coordinates all the family planning activities in addition to his other duties. The population in a block is about 80,000 to 100,000 and the sub-centre or peripheral unit (10,000 population) is in charge of an ANM. She is supervised by a Health Visitor who is in charge of four sub-centres. The Health Assistant (Male) has a responsibility for 20,000 population and is responsible to the Block Extension Educator for motivation. Out of the 5432 Public Health Centres envisaged, 4907 (1970) have been established; the difficulties of the staff are being overcome but in many places, the situation is uninviting.

Action Implementation Committee : (Chart VI). At the State, District and Block levels, implementation committees function with officials and non-officials at the district and block levels, and officials only at the State level, to review periodically the progress of the programme.

Some Observations

Cabinet Sub-Committee : Centre & State : The absence of the Education Minister in the Cabinet sub-committees at the Centre and State indicates that the population policy does not comprehend population education in the schools at the primary and secondary, the University and adult education levels. The need for such a programme is obvious. Unless the age groups 5-20 are exposed to graded population education, it would be well nigh impossible to meet the situation even at the turn of

the century. The responsibility of the Education Ministries for population and health education in addition to student health services is great. There is neither curricular nor extra curricular involvement in population education for the 1.2 million students at the Universities and Colleges who will be the future opinion leaders of the society and parents of tomorrow. There are also no multidisciplinary Population Study Centres in the Universities. There is, therefore, no intellectual climate or public opinion supporting the Government policies. This challenge can be met by the participation of the Ministry of Education and the Department of Education at the Centre and State.

Technical Committees at the Centre and State Levels : The Director-General of Health Services as the head of the organised profession should have greater public relations with the profession both with the specialists and generalists. There is, therefore, need for a professional consultative body meeting frequently at the Centre to give support to the programme. The same situation should exist in the States. This procedure will get the backing of the profession, specialists and generalists to the family limitation programme. The challenge to the profession should be shared and taken up by them which will increase the confidence of the people in the National programme sponsored by the Government.

Conditions of Service of the Workers : The staff in the family planning programme hold posts temporarily. This national programme requires the services of satisfied workers. Unless there is security of service for this large army of workers, the performance of the workers would be below par for want of security. With the target-minded programme and with poor facilities in the rural areas, and with relatively poor prospects awaiting them in the services, the best cannot be obtained out of the workers. It is, therefore, necessary to integrate the family planning posts in the general health services and broad responsibilities given to them to get the best out of the workers. The others, social scientists, etc., should have permanent posts.

Central and State Family Planning Council : This is headed by the Union Health Minister with the Ministers of Health of the States and Territories, representatives of the concerned Health Ministries and various voluntary bodies as members. This Council facilitates coordination and cooperation between the State and Central agencies and between the public and voluntary bodies. This, however, meets only once in a year. The recommendations of the Council are often adopted by the Central and State Governments. The Secretaries and Administrative Medical Officers meet earlier than the Council to discuss problems of implementation and progress.

The State Family Planning Councils meet also once or twice a year to follow the programme in the respective States.

To make a meaningful approach and to obtain greater coordination

with the other health programmes either the Central Health Council and Central Family Planning Council should be amalgamated or joint sessions should be held to give better image of their purpose and function to the public health workers. There should also be more frequent meetings. Zonal meetings should be held once in each zone during the year.

Financing the Programme : The Health programmes are categorised into those which are purely Central, centrally sponsored, centrally assisted and purely State. The Centrally sponsored programmes are not included in the State plan's ceiling and the assistance to States varies from cent per cent to lesser amounts depending on the programme. In the case of the family planning programme, the assistance is cent per cent. The funds are released periodically but the rigidity of the rules are irksome to the State Governments. Though the funds are allocated under various heads, the States are also bound down to definite allotments under approved schemes and even to allotments under individual items. The lack of flexibility restricts activity, and causes shortfalls. The States have no Executive Board comparable to the one that exists in the Centre to speed up the programme. Three-fourths of funds are expended by the State Governments ; Nirodh costs about 8 per cent and about 10 per cent is spent for mass education and training, administration and research. The rest of the allocation is for the Central sector. Shortfalls in expenditure have been a common feature as mentioned earlier. The appointment of an Executive Board at the Centre and some delegation of powers to the States promises some hope. But the procedures are cumbersome and not compatible with concepts of development. Hence greater flexibility within the programme would permit greater opportunity to expand the programme through the incentives.

Family Planning and Health Services : At the Central level, the Director-General of Health Services who is the Chief Advisor to the Government on all Health matters does not take much responsibility for the family planning programme except to be present as an advisor at the meetings of the Cabinet Committees and the Central Family Planning Council meetings. The entire Health services under him do not, therefore, regard the family planning programme as theirs. The same situation exists in hospitals, dispensaries, medical colleges, wherever there is special family planning staff solely performing such duties. The situation in the States is very much analogous. The programme is, therefore, generally isolated from the rest of the general health services, except when surgical work requiring hospital admissions for camps is involved or when their services are requisitioned. This isolation of the programme from other medical and health services and medical education institutions is one of the reasons for the programme not gaining momentum. The Commissioner for Family Planning is not in a position to be in the general stream of the work of the medical and health services to exert sufficient influence on the service and

on medical education. One way of remedying this situation is to designate the Commissioner for Family Planning as Additional Director-General of Health Services and Commissioner (FP) which will give the necessary influence on the general health services of the country and medical education. A similar change appears to be needed in the States, wherever such a situation exists.

It should be incumbent on the entire health services and health profession to consider remedying all hazards to health. Population pressure is now the greatest health hazard because of its effects on the physical, mental and social situations and economic, social and health consequences to the individual and the family. It is, therefore, the responsibility of every health worker to participate in family planning activities from motivation to application of procedures.

Family Planning and the Medical Profession : The medical profession as a whole has neither a say nor are they given a responsibility in the programme though feeble attempts are being made by the Centre and the State Governments to enlist their support. The independent medical profession has the competence to advise, take responsibility, and support the programme in the practice of the profession and as such should be mobilized to the full. The contraceptive methods that are emphasized now like the I.U.D., Oral Pill, the Surgical Sterilization, etc. all require the services and skill of physicians. Not to enlist their support at different levels, *i.e.,* the Centre, State, District, Block has been one of the greatest drawbacks of the programme. The failure of the I.U.D. programme is partly due to the non-utilization of the services of the modern medical profession for follow-up work.

The indigenous practitioners have been approached by the Central Government for cooperation but their services would only be useful in general motivation but not in the extension of this specialised service.

Family Planning and Maternity and Child Health : When the department of family planning was created, the programme was taken up in isolation. Later, the MCH was also taken up in a small way. 21 million pregnant women could have been induced to resort to spacing of the birth of children, if MCH services had been offered. Greater emphasis would have produced an impact on the programme. This programme, therefore, requires a truly integrated approach to get the rural mother interested in family planning in view of the child mortality in 0-5 ages. The suggestion of small family norm does not make an impression, unless the survival of the existing children is assured.

The division of Family Health in WHO includes Fertility Control, MCH, Nutrition and Health Education and this may be of value in the discussion.

Availability of Health Services : Eighty per cent of the population in India are in the rural area. 5432 primary health centres that are expected

to be established in the community development blocks have each a responsibility for 80,000 to 1 lakh of population. Many sub-centres, one for each group of 10,000 persons, are yet to be opened under the Primary Health Centres. In 1969, it is reported that out of the proposed 42,142 sub-centres, only 13,591 under P.H.C. scheme and 10,898 under the family planning programme, bringing the total of such centres to 24,489 were functioning. The situation may be better now. The work load at each sub-centre was double, *i.e.,* on an average a population of 20,000 was looked after by one ANM. At the rate of 40 births per thousand, 800 deliveries would have taken place in the jurisdiction besides the family planning work. It is considered that it is too much for one ANM to look after 10,000 people. The ideal would be one ANM for 5,000 people for combined MCH and family planning work. The quality of the worker is also equally important. Continuing education and retraining facilities are needed which are at present insisted upon. The need for the revival of additional Family Welfare Worker at the sub centre level has been suggested which appears to require examination. The Health Assistants for motivation and family planning education have also a greater work load (one for 20,000 people).

Thus the services available at the periphery are inadequate. The structure is top-heavy with a poor base, which more than explains the failure of realising the targets. As the family planning programme has to be sustained over decades to achieve our objectives, the requisite infrastructure should be developed at the earliest possible time so that total health care with family planning will be available to the people. The failure of IUD programme is largely attributed to lack of after-care. When the health infrastructure reaches smaller numbers of populations, the result will greatly improve as motivation has to be individualised.

Training : At the Central level, the five training institutions train personnel for work at the Centre, States and District levels. The Regional Family Planning Training Centres train programme workers employed at the block level and below. Sixteen Family Planning field units set up to handle the mobile training of the institutional resources are also charged with local community education in addition. The State Planning Training Centres are the major training source for the basic personnel in the extension net-work down to the sub-centre level. Only 20 per cent of the training seats are stated to be used and 50 per cent of all centres are said to be working at 28 per cent capacity. This programme, therefore, requires to be strengthened. The staff of all teaching institutions of health professions have a great responsibility in this area. Unless the programme is taken up as the programme of the DGHS and of all the departments of health at the State level, the momentum of training will continue to be at low key.

State Involvement in Policy Adoption and Implementation : Looking at the performance of various States (Appendix I) the achievements may be considered unequal. The fact that States like Punjab, Maharashtra, Tamil

Nadu, Andhra Pradesh, etc., have done better than others, notwithstanding the lack of freedom for innovation and policy, shows that with determination, other States also could do well within the existing framework. However, there is need for a review of the present devolution of powers with regard to the programme. The States should be asked to develop family planning programme for their areas and plan their programme within the general overall policy so that, with the participation of the people, the profession and the voluntary organisations, the programme objectives can be attained. This would, in the shortest possible time, undoubtedly bring about greater involvement of the States.

Local Authorities : At the *panchayat* and *zilla parishad* levels, the involvement is equally wanting. Each local authority in the geographic areas should have its own responsibility for the total health care and social development. The authority will then be able to enthuse the community leaders, local voluntary organisations and all the workers in their service for creating the necessary climate for action for fertility control for better health, better living conditions and better social conditions. Unless the macro approach is replaced by the micro approach of development of the district, *panchayat,* the town and the village and the family, participation in the programme would not become meaningful to the people.

Development means change and growth. Change includes social and cultural elements. Growth includes levels of living and economic progress. This should be at the macro and micro levels. With the rapid growth of population, the micro level income continues to be low. The GNP has no meaning to the family or individual unless growth occurs at his level. This can only happen when the economics of the small family norm is understood. How to put across the concept and make this programme meaningful is one of the major problems requiring the attention of the local bodies. The results of participation of *panchayats, zilla parishad* and the community in an intensive district programme in Kerala recently has demonstrated great possibilities. Total support from all parties would open new gateways for extension of the programme.

Involvement of Elected Representatives : As this programme is a war on want, hunger, and disease, the national consensus will give a new dimension of attack. Greater involvement of the elected representatives at all levels will boost the programme considerably.

Non-governmental Organisations : Health and welfare require community effort. In this, public services, private institutions, the voluntary organisations and the people should jointly participate. The voluntary organisations are eminently suited to motivate through education and other welfare measures. They could also undertake several functions :

1. Mass communication, education and motivation for family planning at the local community level.
2. Undertaking of research, experimentation and documentation to

improve knowledge for programme planning purposes.

3. Stimulating community action to contact each married couple and especially those with new born children, and to secure acceptance of the small family norm by these couples.
4. Conducting pilot projects to identify ways and means for successful implementation of birth control measures.
5. Cooperating with relevant Government agencies, so that the efforts of the voluntary sector in motivation of people can be followed up by Government-provided services.
6. Creating public opinion on social reform aspects of the family planning programme, such as the small family norm, abortion, age of marriage, attitude toward bachelors, religious role of sons in families and inheritance laws.

Recent reports of the study teams of the Population Council of India reveal many difficulties which include late receipt of grants and too many restrictive regulations. There is need, therefore, to mobilize all forces to assist community effort for the speedy attainment of the objectives of family planning and institute the necessary administrative and financial reforms to encourage voluntary effort in rural India.

Motivational Programme : Two major methods of communication are used : (1) Mass media; (2) Extension education. In addition to these, incentives are also in use. Innovations should give clues to motivational approach. The SITE (Satellite Television experiment) programme seeks to cover literacy, population problems and agricultural innovations. With the introduction of T. V., the much-desired audio-visual mass media will greatly help to stir up the rural sector.

The introduction of education bonds for children's education, provided there is a small family (2 or 3 children), deserves further consideration. Social security schemes in some form and old age pensions after 65 for acceptors are worth a trial.

Social and legal aspects : Raising the age of marriage for men and women, women's education and employment, liberalisation of abortion, child care and prevention of child labour and social security are some of the measures to be taken up for social development which have a bearing on fertility limitation.

Population Policy

The need for a new population policy has been stressed at the National Conference (1969) on Population Policy and Programmes. The policy resolutions approved at this Conference stated that the population of a country should be regarded not only in terms of numbers but also in terms

of its distribution and its composition and structure in relation to resources. The resolution also covered the following :

(*a*) In promoting fertility control, the State will strictly respect the voluntary choice of married couples influenced by information and motivated by persuasion; legal compulsion must be avoided. Consequential growth rates for various regions and sub-regions of sufficient homogeneity should be established after systematic surveys and assessment of feasibilities in the light of knowledge, attitudes and practices.

(*b*) The small family norm, established through fertility control and voluntary spacing of offspring should receive priority. This will call for enlightenment of a much wider band than that of the fertile married couples. This can be achieved through extensive population education. This would also necessitate a massive programme of mass communication. Community pressures through local leaders and voluntary agencies should also be utilised to achieve these objectives.

(*c*) The population policy should also concern itself with quality of life of the people in the context of socio-economic development. The rate of development as well as distribution system of economic benefits constitute an important aspect of the population policy.

(*d*) A policy for internal and rural urban migration, as well as resettlement of Indian immigrants of Indian origin from abroad and export of technical manpower from India, should be carefully planned.

(*e*) Similarly, a broad-based population policy should pay adequate attention to educational policy and, in particular, to the infrastructure, necessary to educate the new generation. It is also essential to consider the process of urbanization and evolve a policy for location of industries as well as regional development, so as to remove regional imbalances.

(*f*) Since the employment and emancipation of women, as well as the transformation of a traditional society, have relevance for a broad-based population policy, these aspects must be taken into consideration while framing the policy. To achieve this, it will be necessary to change the focus of family planning programmes from a clinical to a social welfare approach.

(*g*) The population problem should be designed to reach appropriately individual manageable groups of population, such as groups in the organized sector. While doing so, it would be advisable fully to involve non-official agencies so as to make the impact deeper and more extensive.

(*h*) Since a uniformly acceptable and permanent population policy cannot be quickly devised, constant research should be carried on, so that the best knowledge and experience can be applied to assure the most effective implementation of the country's population programmes.

Mr. Robert S. McNamara, President, World Bank, in his address in September 1970, focuses on five ingredients to achieve results. These are : (1) The political will to support effort ; (2) The required understanding and the willingness to act on the part of the people ; (3) The availability of effective, acceptable birth control methods; (4) An efficient organisation to administer the programme ; and (5) Demographic data and analyses to evaluate results and discover weakness requiring correction.

Where do we stand on each of these ? This may be a question we may take up for our situation.

In an inspiring message to the recent Regional Conference on Population at Lucknow, the Prime Minister stated as follows :

> "The importance which the Government attached to the population limitation programme has been brought out forcefully in the President's address to Parliament. We are determined to pursue policies which will make a small family the norm."

CHART I

ORGANIZATION FOR FAMILY PLANNING AT THE CENTRE

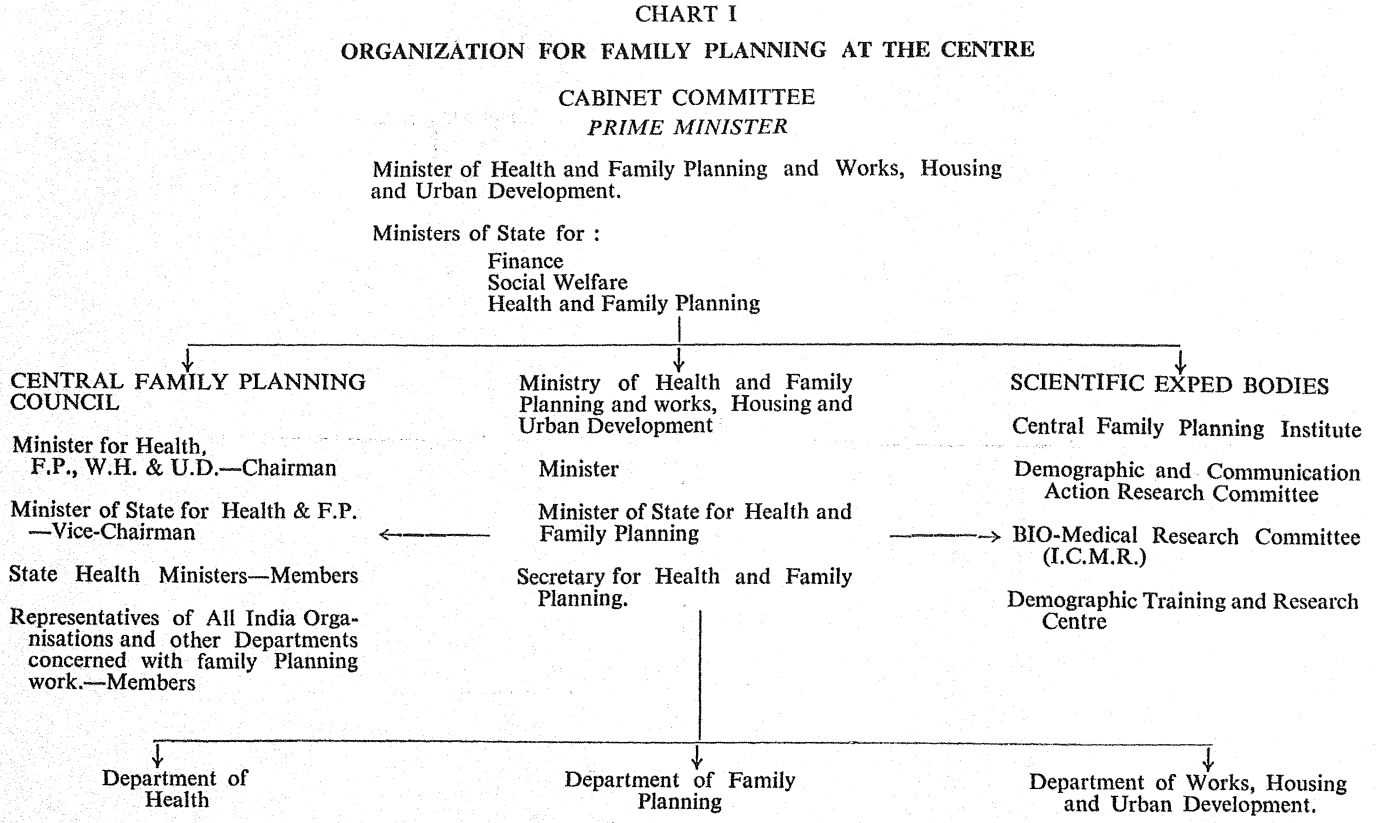
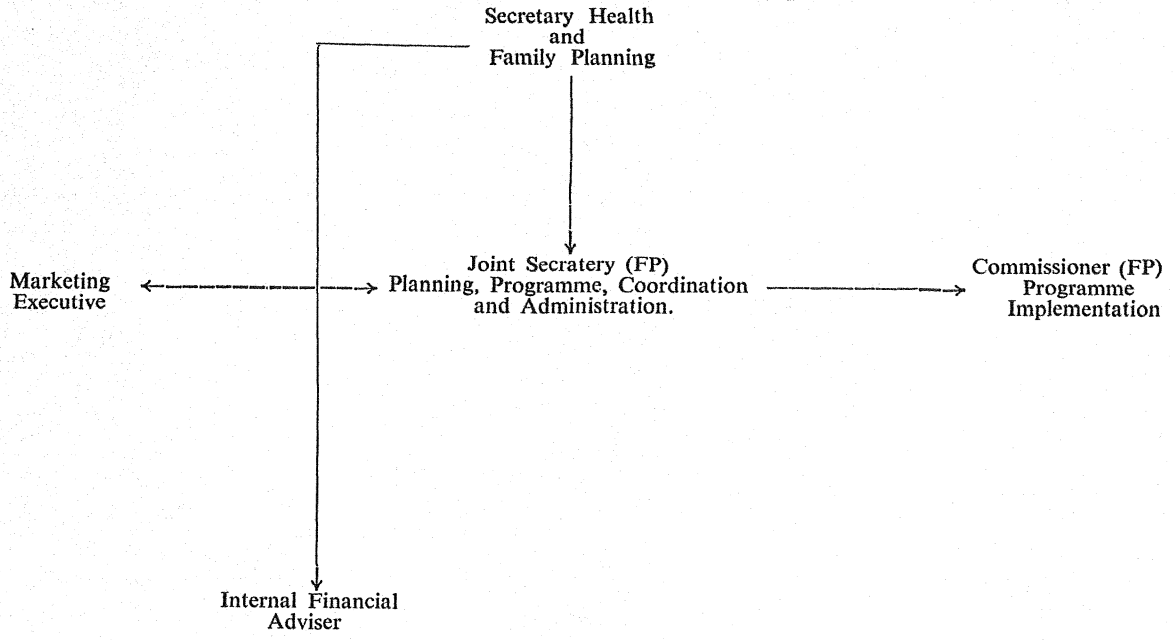


CHART II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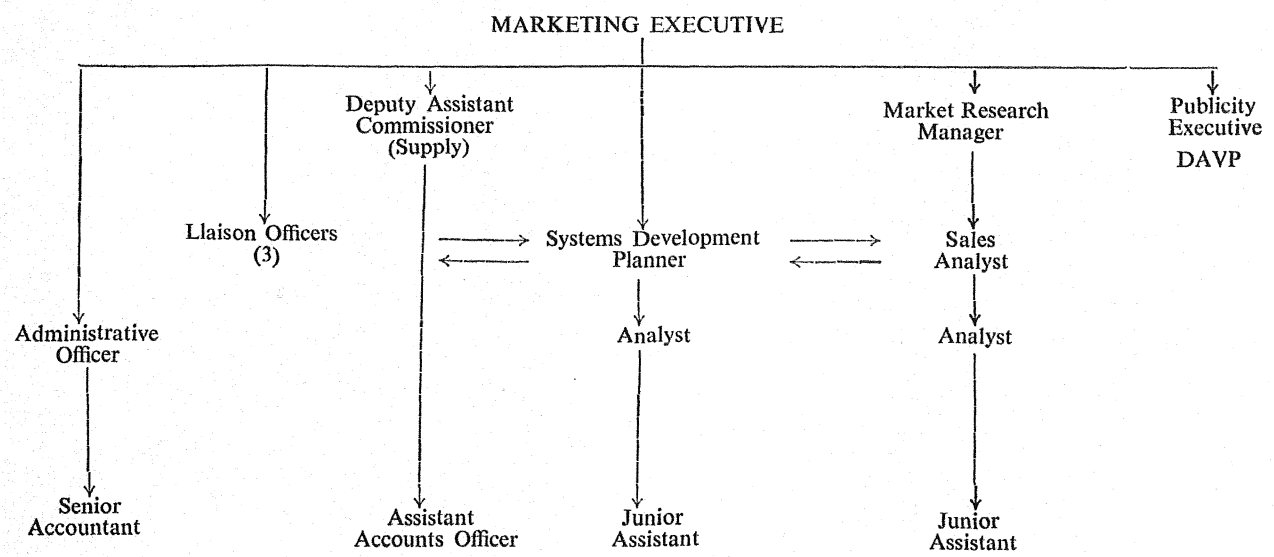
and
Family Planning
Marketing
Executive
Joint Secratery (FP)
Planning, Programme, Coordination
and Administration.
Commissioner (FP)
Programme
Implementation
Internal Financial
Adviser

CHART III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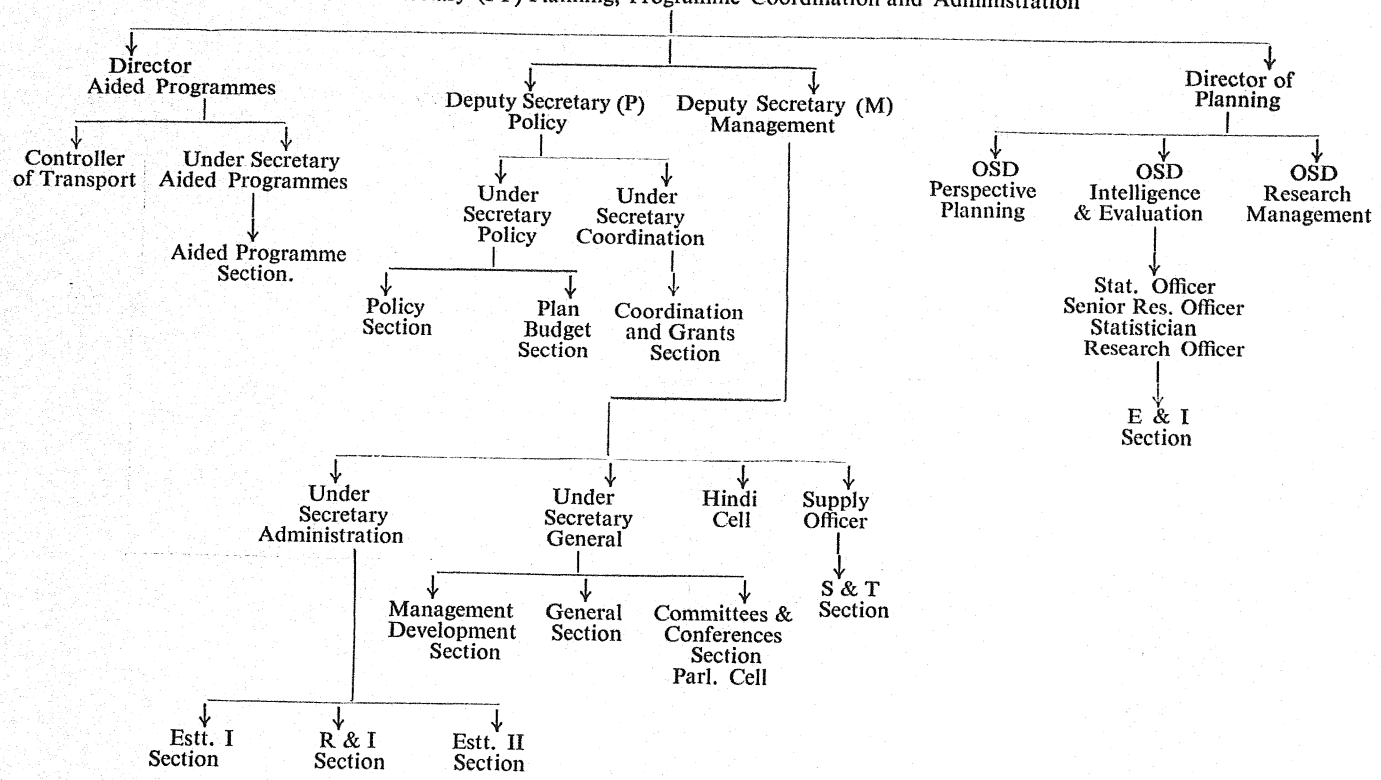
Deputy Assistant Commissioner (Supply)
Market Research Manager
Publicity Executive
DAVP
Llaison Officers (3)
Systems Development Planner
Sales Analyst
Administrative Officer
Analyst
Analyst
Senior Accountant
Assistant Accounts Officer
Junior Assistant
Junior Assistant

CHART IV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Director Aided Programmes
Controller of Transport
Under Secretary Aided Programmes
Aided Programme Section.
Deputy Secretary (P) Policy
Under Secretary Policy
Policy Section
Plan Budget Section
Under Secretary Coordination
Coordination and Grants Section
Deputy Secretary (M) Management
Director of Planning
OSD Perspective Planning
OSD Intelligence & Evaluation
Stat. Officer
Senior Res. Officer
Statistician
Research Officer
E & I Section
OSD Research Management
Under Secretary Administration
Estt. I Section
R & I Section
Estt. II Section
Under Secretary General
Management Development Section
General Section
Committees & Conferences Section
Parl. Cell
Hindi Cell
Supply Officer
S & T Section

CHART V

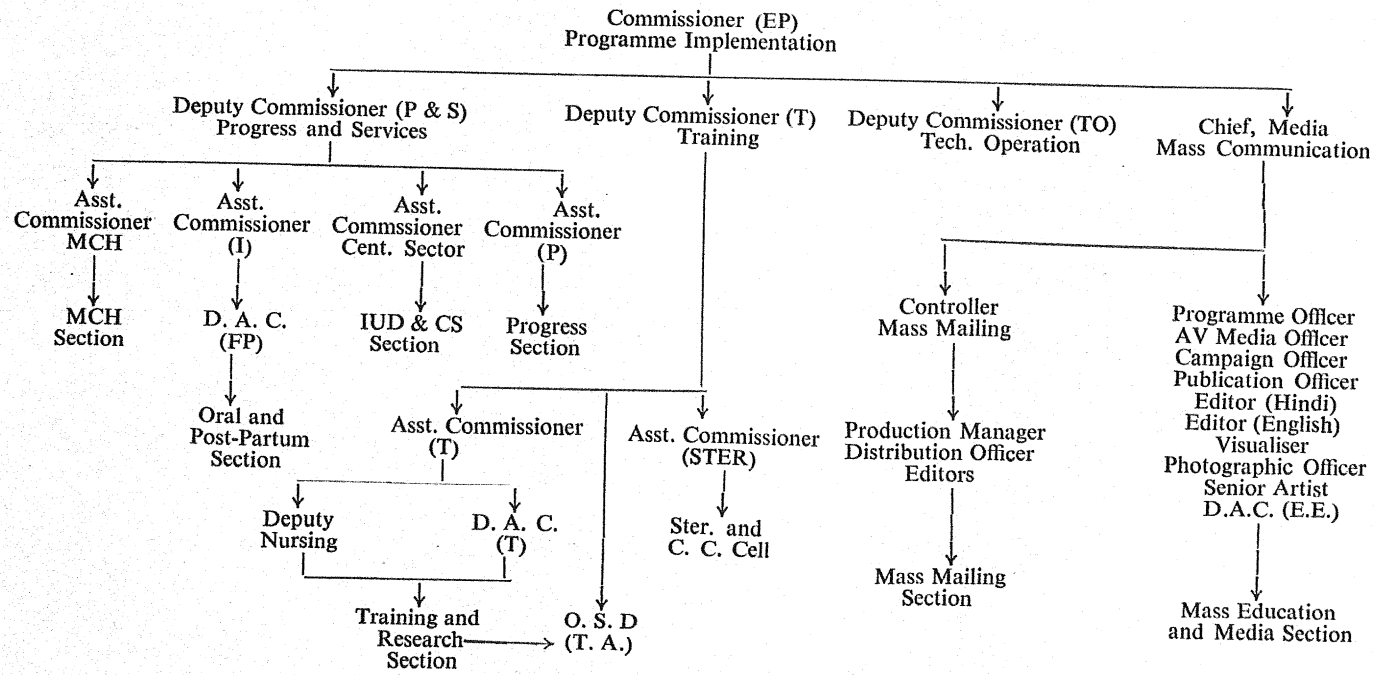

Commissioner (EP)
Programme Implementation
Deputy Commissioner (P & S)
Progress and Services
Deputy Commissioner (T)
Training
Deputy Commissioner (TO)
Tech. Operation
Chief, Media
Mass Communication
Asst. Commissioner MCH
Asst. Commissioner (I)
Asst. Commssioner Cent. Sector
Asst. Commissioner (P)
MCH Section
D. A. C. (FP)
IUD & CS Section
Progress Section
Oral and Post-Partum Section
Asst. Commissioner (T)
Asst. Commissioner (STER)
Deputy Nursing
D. A. C. (T)
Ster. and C. C. Cell
Training and Research Section
O. S. D (T. A.)
Controller Mass Mailing
Production Manager
Distribution Officer
Editors
Mass Mailing Section
Programme Officer
AV Media Officer
Campaign Officer
Publication Officer
Editor (Hindi)
Editor (English)
Visualiser
Photographic Officer
Senior Artist
D.A.C. (E.E.)
Mass Education and Media Section

CHART VI

ACTION/IMPLEMENTATION COMMITTEE

I. At State Level

Chief Secretary	*Chairman*
Development Commissioner	*Member*
Health Secretary	*Member*
Director of M & HS	*Mamber*
Other important State officers	*Members*
Regional Director	*Member*
Joint Director (FP)	*Secretary*

II. At District Level

Collector	*Chairman*
Chairman, Zila Parishad	*Seven Members*
Civil Surgeon	
District Planning Officer	
District Health Officer	
Other important district officers and non-officials	
District FP Officer	*Secretary*

III. At Block Level

Chairman or President of Panchayat Samiti Union or Anchalik Panchayat	*Chairman*
Elected representative of the Samiti	*Member*
Block Medical Officer	*Members*
FP Extension Workers	*Members*
Block Development Officer	*Secretary*

CHART VII

ORGANISATION FOR FAMILY PLANNING IN A STATE

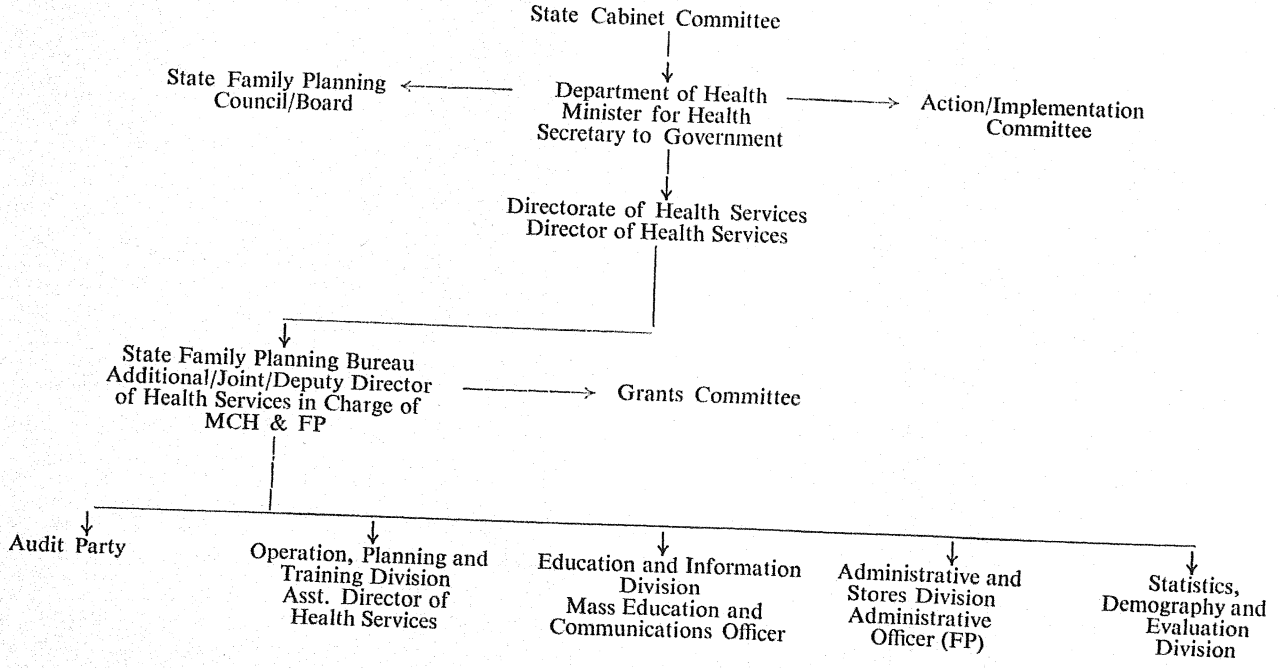


CHART VIII

ORGANISATION FOR FAMILY PLANNING IN A DISTRICT

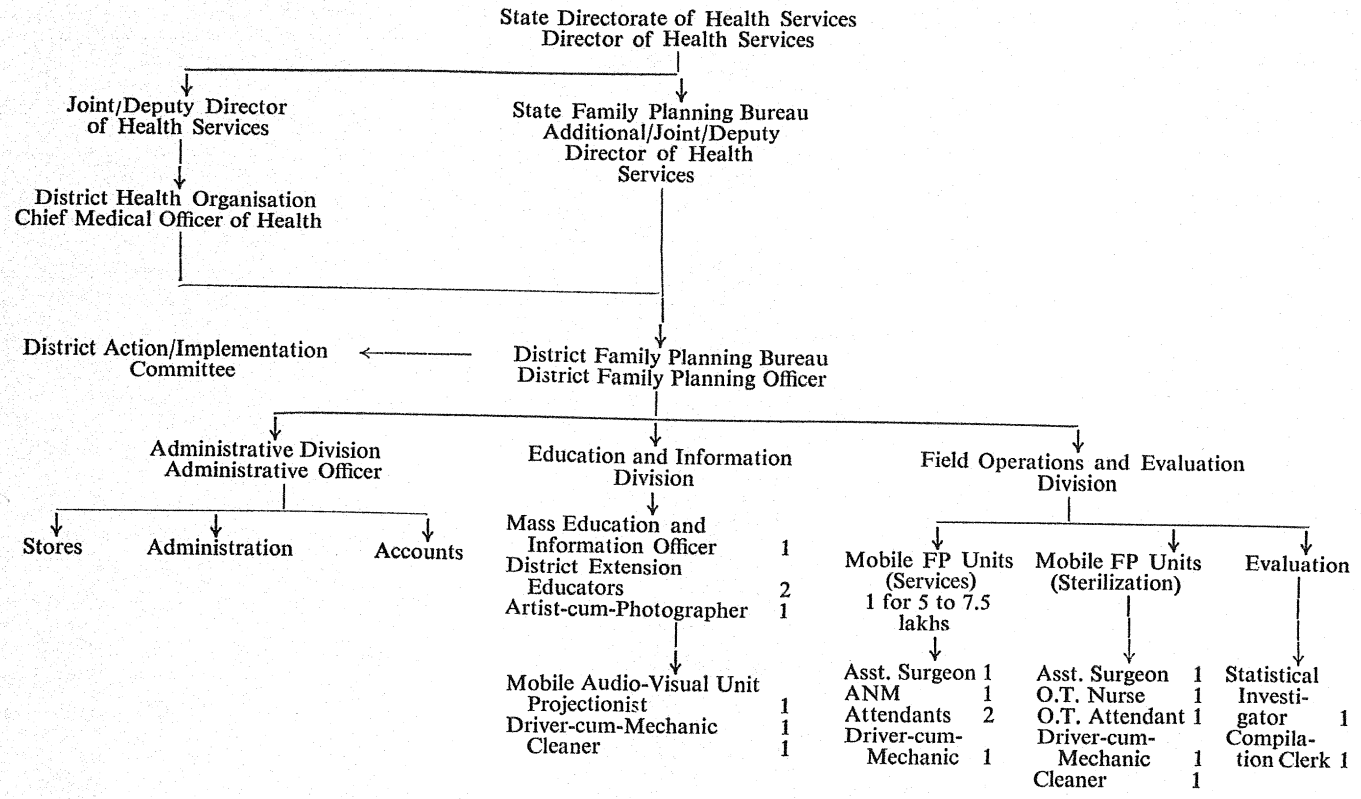
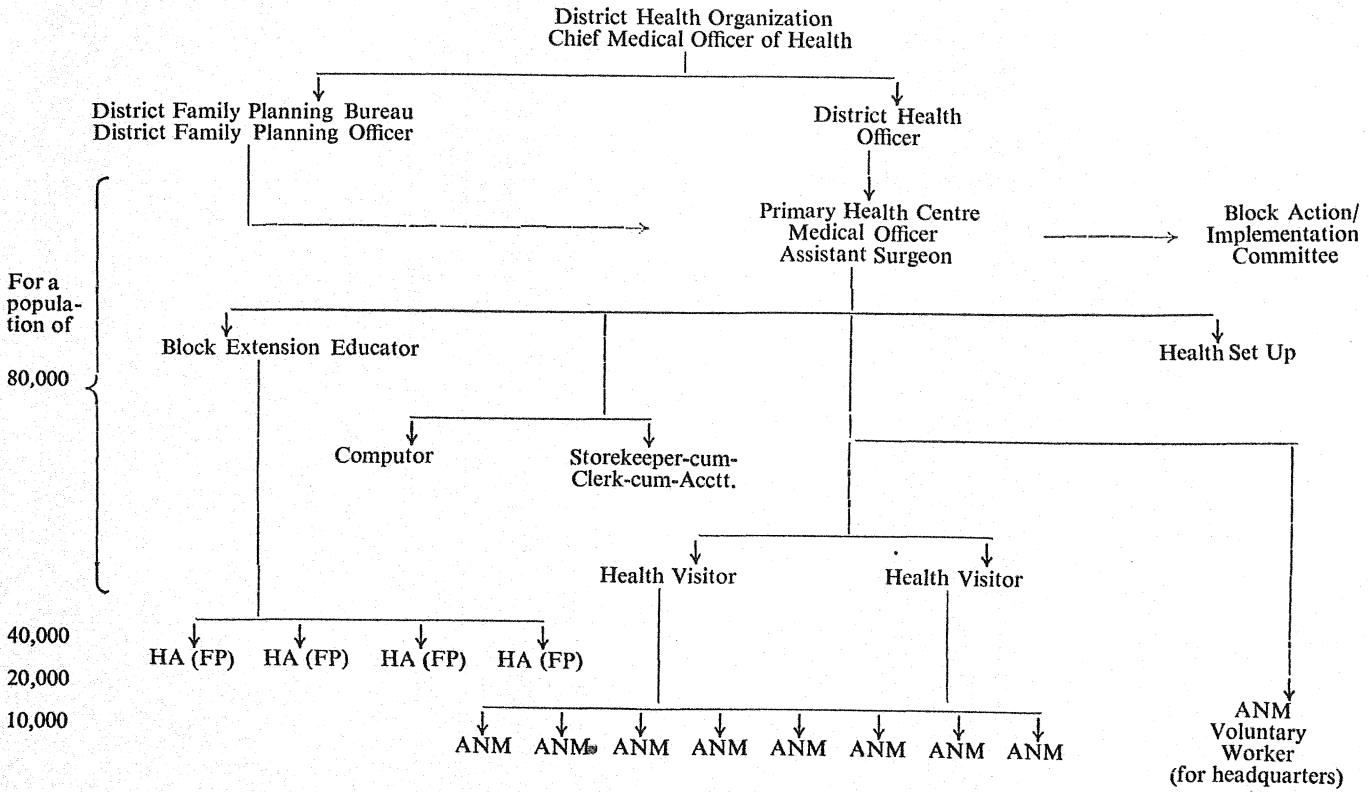


CHART IX

ORGANISATION FOR FAMILY PLANNING AT A BLOCK



APPENDIX 1

URBAN FAMILY WELFARE PLANN NG CENTRES IN STATES AND UNION TERRITORIES

State/Union Territory	Required	Functioning	Percentage
1. Andhra Pradesh	142	198	139.4
2. Assam	22	15	68.2
3. Bihar	91	87	95.6
4. Gujarat	127	107	84.3
5. Haryana	32	30	93.8
6. Jammu & Kashmir	13	11	84.6
7. Kerala	60	34	56.7
8. Madhya Pradesh	109	91	83.5
9. Maharashtra	264	220	83.3
10. Mysore	123	50	40.7
11. Orissa	26	54	207.7
12. Punjab	63	100*	158.7
13. Rajasthan	79	70	88.6
14. Tamil Nadu	201	82	40.8
15. Uttar Pradesh	220	206	93.6
16. West Bengal	205	123	60.0
17. Nagaland, Union Territories and Central Government Institutions	79	297	375.9
ALL INDIA	1,856**	1,775***	95.6

*Under Clarification.

**On the basis of one centre for 50,000 population.

***Includes various types of centres serving different populations.

A NEW APPROACH TO MEDICAL PLANNING

DR. P. K. MISHRA*

The establishment of a National Health Service on the pattern obtaining in U.K. has been regarded as our objective in the field of medical care. We are now in the midst of the 4th Five Year Plan and it is worth-while to have a fresh look as to whether our efforts are leading us towards the desired goal.

At the time of Independence, an average district had only a small poorly equipped hospital at the district headquarters. Apart from the Civil Surgeon, there were 2 or 3 doctors with a minimum of ancillary staff. There were 28 medical colleges in 1948 with an admission of 2,710 per year. The total number of doctors in the country was around 48,000 giving a ratio of one doctor for 6,300. The bed population ratio was 0.24 per thousand. There was hardly any organized effort to control major communicable diseases.

As a result of our development effort during the successive Plans, the country now has a total number of 2,55,700 beds amounting to 0.49 bed per thousand. Out of these, 24.7 per cent of beds are available at the teaching hospitals, 30.2 per cent in district headquarters, 25.2 per cent in *tehsil* headquarters and only 10.9 per cent in the Primary Health Centres. The facilities at the Primary Health Centres provide significant services to a bare 10 per cent of the population. 95 medical colleges have already been established and the total number of medical colleges is likely to be increased to 103 at the end of the 4th Plan period. The annual intake in these medical colleges is also expected to increase to 13,000 at the end of the Plan. The total number of doctors in 1970 was estimated around 1,09,000, giving a ratio of one doctor for 5000 people. 80 per cent of the doctors are practising in urban areas. Consequently, the doctor population in urban areas is one for 1000-1250 people.

Delhi has a total of 9,618 beds amounting to 2.38 beds per thousand population. As the major hospitals are concentrated in the North, Central and South parts of Delhi, large areas of pouplation residing in the West Delhi and Shahdara do not have the benefit of a major hospital. During the 4th Five Year Plan, it is proposed to construct one 500 bedded hospital

*Director, Health Services, Delhi.

in each of these areas to correct this geographical imbalance. A large number of dispensaries have been provided under various agencies. Those belonging to the Employees' State Insurance Scheme and the Central Government Health Scheme are not open to the members of the general public. Dispensary services in Delhi are proposed to be augmented on the basis of one dispensary for 25,000 population during the 4th Plan period.

Remarkable success in the control of communicable diseases has, however, added new dimension to our problems, namely, the rapid growth of population. This new factor threatens to neutralise the entire gains in the country. The consequences of an unchecked growth in the population has been compared by Lord Snow to a nuclear holocaust—an event of cataclysmic proportions which might result in the destruction of the entire fabric of an organised civilised society.

With the medical base already established—we are now in a position to give a more precise direction to the planning of our services in the light of our future needs and immediate objectives.

It would appear that the future planning in the medical field should broadly have two main objectives : (*i*) to ensure, concurrently with our efforts to control communicable diseases, a substantial reduction in the growth rate of population fairly rapidly, and (*ii*) to provide a base for medical care services which can subsequently transform itself into a National Health Service. I hope there would be a general acceptance of these two broad objectives.

From these objectives one can proceed to enunciate certain principles that ought to be satisfied for the success of any mass welfare programme :

1. It should provide a direct and effective participation of the people at various levels of administration.
2. It should aim at securing the willing co-operation of the professional organisation concerned.
3. Its organizational base must be sufficiently broad both for initial responsibilities and future expansion
4. The system should provide for future adaptability and growth in accordance with changes in objectives.
5. The scheme must aim to provide full satisfaction in at least some small sphere of its activity in order to create the necessary confidence. The focal point for determination of this adequacy is to be directed by consideration of health priorities.
6. The scheme should be free from unnecessary cost of administration.

The existing planning in the field of medical care does not appear to satisfy any of the above tests. The facilities are most meagre where they are most needed. In the context of shortages of medical personnel, hospital beds and, above all, the overwhelming compulsion to reduce the birth rate within a decade, a sectoral approach is not desirable. In particular, the

medical profession as represented through the Medical Association has, by and large, kept itself aloof both from the formulation of policies as well as its implementation. The existing medical care structure can hardly be expected to transform itself to assume larger responsibilities of providing a comprehensive National Health Service as its base is too rigid and narrow. Likewise, in trying to provide everything—everything is being provided in an inadequate manner, leading to disenchantment or even dissatisfaction with the Government and its related departments. The absence of active population support is, perhaps, the greatest single weakness of the Family Planning and other national programmes in the country.

The plan outlined below is being offered as an alternative to current planning.

If the entire Union Territory of Delhi was to be covered on the basis of the Central Government Health Scheme during the next 15 years, it would entail an expenditure of Rs. 155 crores and would require the employment of 3471 doctors, including 671 specialists. It is, therefore, obvious that medical facilities on this pattern and scale could not be provided for the people in the near foreseeable future. A comprehensive plan of Health Services, however, is not indivisible in time. If, therefore, the range of services to be provided are reduced and the coverage of the persons is also restricted, it would be possible to bring down the expenditure to manageable limits.

The scheme outlined below is based on the above assumption. 'It uses experience but is not tied by experience'. The broad features of the scheme are as follows :

(*a*) The basic area unit under this plan would be a block of 50,000 population.

(*b*) Each block of 1000 families (5000 population) in the area will be allocated to one doctor.

(*c*) Free services of doctors will be available only for children in the age group of 0—5 years. It is anticipated under this arrangement that each doctor will be looking after about 1000 children.

(*d*) The free services of the doctor will be limited to :

- (*i*) Consultation for children under 5 years of age.
- (*ii*) Total immunization of children under the same age group.
- (*iii*) Family Planning work including I.U.C.D. and vasectomy, where necessary.

On this basis for a population of 40 lakhs in Delhi (including 8 lakhs children), 800 doctors will be required to provide the services. It is anticipated that the requisite number of doctors to meet this demand will be available from amongst the private practitioners in Delhi.

It is not proposed to make any drastic change in the existing organisational set-up. An additional cell will be created in the Directorate of of Health Services to deal with this scheme exclusively. Apart from this,

the following committees will be set up :

(*i*) *Central Medical Committee*
This will be a policy-making body representing various interests. The Executive Councillor concerned will be the Chairman.

(*ii*) *A Technical Committee*
This would be a committee of experts under the Director, Health Services, Delhi. This Commitee will report directly to the Executive Councillor concerned.

(*iii*) *A Zonal Committee*
This committee will be concerned with coordinating medical and health activities in a specified zone. The members amongst others will include the Medical Superintendent of the major hospital in the zone, Zonal Health Officer and respresentatives from the Citizen Committees in the Zone.

(*iv*) *An Area Citizen's Committee*
This would be a committee for each block of 50,000 population. This may consist of the Metropolitan Councillor as Chairman, two Municipal Councillors of the area, one representative of Delhi Medical Association and two members of the general public. The doctors joining this scheme will enter into a contract with the Area Citizen's Committee which will be responsible for the documentation and allocation of children to each of the doctors and the payment of their remuneration and other duties. The Family Planning Welfare Centre of the area will be the Headquarters of this Committee which will have the assistance of a clerk, a peon, etc., paid for by the Family Planning Department.

A system of interlocking membership between different committees would be a useful device.

Under the small-pox eradication programme, one vaccinator is provided for 25,000 population in urban areas. These vaccinators will also be attached to this centre and would function under this Committee.

The Government shall place at the disposal of each of the Area Citizen Committee, the requisite amount for payment of remuneration to the doctors and would also make available the necessary supply of vaccine, family planning contraceptives and publicity material, etc.

The existing technical organization will continue to discharge their technical supervisory duties through this organization.

The modified Family Welfare Planning Centre is shown in Appendix 'B'.

At present, one Family Planning Centre has been sanctioned for a block of 50,000 population. Under the scheme outlined above, the staffing pattern of a Family Planning Welfare Centre would be modified. These savings would be available for payment to the doctors within the area of of each of the Family Planning Centres under the new scheme. Under

this arrangement, the Family Planning Department will also provide triple vaccine. The small pox eradication programme and the T. B. control programme will provide the small pox vaccine and the B.C.G. vaccine respectively.

The additional cost to the Government under the new arrangements would, therefore, relate to :

(*a*) Any payment to the doctors in excess of the savings from the Family Planning Programme.
Various alternatives are shown in Appendix A. There will be no objection to employing retired teachers, accountants, etc., for various types of duties in a centre.

(*b*) Slight additional expenditure in the modification of the existing administrative structure to meet new duties and responsibilities.

As a general principle, it can be stated here that the success of the scheme would depend upon the co-operation of the medical profession.

The plan in spite of its apparent simplicity, nevertheless envisages radical departures from the existing practices and is likely, therefore, to have far-reaching consequences. The radical changes involved are in tune with our current mood and thinking.

The identification of each family with a doctor, is in itself, a giant step forward.

The built-in integration of family planning services with the general health services is the corner stone of the plan. This, along with its wider popular base and the special emphasis on meeting the health and medical needs of the children augurs well for the success of the family planning and other national programmes in the country.

The proposed plan can be evolved out of the existing set-up without serious dislocation.

The plan is the starting point of a dynamic process. Its organizational base is broad and flexible enough to accommodate changes in objectives and acceptance of additional responsibilities, in an orderly manner. The scheme, therefore, can easily be transformed into a National Health Service, when resources permit.

The ability to absorb voluntary offers of services/donations from individuals and/or institutions is a notable feature of the scheme.

The plan seeks to bring under one management a large number of services which have remained scattered, not by design but for historical reasons.

The scheme would greatly facilitate collection of vital statistics.

The involvement of the medical profession on this scale would ensure prompt remedial action in case of an epidemic.

The formation of the Zonal Committee around the Medical Superintendent of the Zonal Hospital has been evolved to ensure a close and continuing contact between the Zonal Hospital and the community in its

catchment area. It is intended, under this mechanism that the Zonal Hospital would participate more directly and to a fuller extent in the medical care of the community in its zone.

The proposed system of a contractual arrangement of the profession with the local Citizens' Committee has been designed to balance the independence and dignity of the medical profession on the one hand and their social obligations to the community on the other. This arrangement, it is hoped, would result in greater harmony. In this case, the local Citizens' Committee is expected to transform itself into a voluntary agency, not only for the tasks specified but also to provide for *other unmet needs* of the community.

Though the scheme has been designed primarily for the Union Territory of Delhi, it is obvious that it could also serve as a model for urban and semi-urban areas throughout the country. The planners would no doubt also perceive its applicability and relevance to the rural areas with suitable modification.

To give effect to the plan outlined in this note requires decisions of two kinds : decisions of principles, decisions of execution and detail. Decisions of principles can be taken now on the basis of the facts and estimates presented above. Decisions of execution and detail will have to be worked out in consultation with the concerned departments of the government, representatives of the medical profession and others.

The plan, to borrow the oft-repeated but much-maligned expression is a "peoples' plan". It involves the people both at the executive as well as the policy level. This is a plan which tends to put democracy to work—the government acting as a mere catalyst. This, it is hoped, would result in a tremendous release of popular will and energy, which would make any talk regarding constraints on resources meaningless.

The problems facing us are vast and varied. We are now, as it were, at the cross roads in our country. This is hardly the time for a timid or halting approach. The approach outlined in the scheme has been dictated by these considerations. In a free society like ours, where no opinion is barred either on account of its unfamiliarity or its incompatibility with prevailing prejudices, there may be a great deal of error as well as insight. This need not deter us; as Thomas Jefferson said, "Errors of opinion may be tolerated as long as reason is left free to combat them'.

APPENDIX A

LIKELY SAVING FROM ONE FAMILY WELFARE PLANNING CENTRE COVERING 50,000 POPULATION FOR FINANCING THE NEW SCHEME

		Amount saved (Rs.)	Payment per doctor per month available from the saving (Rs.)
I.	Abolition of the post of Medica Officer.	9550	80
II.	*Abolition of the posts of :*		
	(*a*) Medical Officer	9550	
	(*b*) Extension Educator (M)	5515	
	(*c*) Family Welfare Worker (F)	3293	
	TOTAL	18358	153
III.	*Abolition of the posts of :*		
	(*a*) Medical Officer.	9550	
	(*b*) Extension Educator (M)	5515	
	(*c*) Family Welfare Worker (M)	3293	
	(*d*) Family Welfare Worker (F)	3293	
	TOTAL	21651	180
IV.	*Abolition of the posts of :*		
	(*a*) Medical Officer	9550	
	(*b*) Extension Educator (M)	5515	
	(*c*) Extension Educator (F)	5515	
	(*d*) Family Welfare Worker (M)	3293	
	(*e*) Family Welfare Worker (F)	3293	
	TOTAL	27166	226
	Staff Pattern of Family Welfare Planning Centre :		
	(1) Medical Officer	1	
	(2) Extension Educators	2	(1 Male & 1 Female)
	(3) Family Welfare Workers	2	(1 Male & 1 Female)
	(4) Store-Keeper-cum-clerk	1	
	(5) Class-IV	1	
	(6) Sweeper (Part-time)	1	

APPENDIX B

STAFFING PATTERN FOR FAMILY WELFARE PLANNING CENTRE FOR 50,000 POPULATION

Existing		Proposed in the New Plan	
1. Medical Officer (Whole-time)	1	1. General Practitioners	10
2. Public Health Nurse/ Family Planning Extension Educator	1	2. Public Health Nurse	1
3. Family Planning Extension Educator (Male)	1	3. —	
4. Family Planning Welfare Worker (Male)	1	4. Family Planning Welfare worker (Male)	1
5. Family Planning Welfare Worker (A.N.M.)	1	5. —	
6. Store-keeper-cum-clerk-cum-accountant.	1	6. Store-keeper/Accountant	1
7. Attendant (Class-IV)	1	7. Attendant	1
8. Sweeper	1	8. Sweeper	1
		9. Vaccinators (from small-pox eradication programme).	2
		10. B.C.G. Technician (from T.B. control programme) for two centres.	1

APPENDIX C

PLANNING EQUIVALENTS

50,000 Population	=	10,000 Families.
	=	8,000 Eligible Couples (16 per cent)
	=	10,000 Children (0–5 years)
	=	10 Doctors @ one per 1000 children.
	=	One Metropolitan Councillor.
	=	Two Municipal Councillors.
	=	One Family Planning Welfare Centre (existing pattern) (Cost Rs. 34,000/- per year)
	=	200 sputum positive cases of tuberculosis.

ISSUES AND PROBLEMS IN THE ADMINISTRATION OF FAMILY PLANNING PROGRAMME AND POLICY

S. D. KAPOOR*

The Nature of Current Policy

In a widely-discussed paper, Davis has severely criticized current population programmes. He seems to be criticising the term "family planning" also, when he says :

> "As is well known, family planning is a euphemism for contraception. The family planning approach to population limitation, therefore, concentrates on providing new and efficient contraceptives on a national basis through mass programmes under public health auspices."

When the terms *population control* and *population planning* are used as synonyms for current family planning programmes, they are misleading. Technically, they would mean deliberate influence over all attributes of a population, including its age-sex structure, geographical distribution, racial composition, genetic quality and total size. No government has attempted such a full control. By tacit understanding, current population policies are concerned with only the *growth* and *size* of populations. By implication, the policies seem to promise a great deal. But actually, current policies labelled population control do not deal with mortality and migration; they deal only with birth inputs. This is why another term, *fertility control,* is frequently used to describe current policies. The family planning movement, heavily devoted to the improvement and dissemination of contraceptive devices, states again and again that its purpose is that of enabling couples to have the number of children they want. It has been stated that the "planning" in family planning is that of each separate couple. The only control they exercise is control over the size of their family. Thus, looking to the side of goals, one finds that a family planning orientation limits the aims of current population policy. Despite reference to "population control" and "fertility-control" which mean determination of demographic results by and for the nation as a whole, the movement gives control only to couples.

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In short, the critical arguments against the current policy are such as: 'Unless we take note of the traditional social structure of India, the subsistence economy and mass illiteracy while formulating any family planning programme, our efforts are bound to be halting, to languish, or even to fail. In other words, population policy is not the same thing as population control policy".

Issues

1. Does a policy *per se* exist on family planning?
2. What policy exists today? Is it contraceptive, birth control, family planning, fertility control, population limitation, or population policy as such?
3. For whose benefit are we planning—family, society or the nation?
4. Is the family being *planned* or *planning?*
5. Do we need a new term with a new policy?
6. Would the *couples* be able to plan the size of the *nation's* population? or, would the millions of decisions about family size made by couples in their own interest automatically control population for the benefit of society?
7. If undue emphasis on contraceptive technology is correct, has the current policy utilized all available means of contraception, including tall birth-control measures?
8. Is it true that by stressing the right of parents to have the number of children they want, it evades the basic question of population policy, which is how to give society the number of children they need?
9. What steps need to be taken up for reconciling the requirements of the individual with the requirements of the nation?
10. Should there be an element of compulsion?
11. Does the current policy need delineating *precise* long-range and short-range goals?
12. To what extent have the family planning policy and programme been accepted and to what extent have they been opposed within the inter-intra-government and non-governmental sectors?
13. What level of priority could be placed in the policy for creating awareness and acceptance of the programme in the *younger generation?*
14. What should be the extent of involvement of non-governmental (voluntary) agencies in the programme and policies?
15. How can the necessity of economic growth be related with population growth? Will it need one comprehensive economic policy or two separate policies; one for economic growth and another for reducing population trend?

16. Is there a much greater need to initiate research on the intermediate and indirect variables affecting fertility so that the ingredients of a population policy can be considered in detail?

Centre-State Relations

Though the government can claim due credit for the progress, one is not unmindful of the fact that the progress has not been as fast as one would like it to be. That the implementation of the programme in certain aspects has been rather tardy is demonstrated by the under-utilization of the funds placed at the disposal of some of the State Governments. It is rather a paradox that, while on the one hand funds and resources are made available, keeping in view the urgency of the programme and the need for achieving quick results, substantial amounts remain unutilized in some States. The U. N. Mission (1969) while evaluating the national Family Planning Programme of India has particularly invited attention to the possibility of modifying the method of allocating Central Government funds to the States in order to eliminate excessive uniformity and rigidity in the staffiing and content of programmes at the local level. It has also recommended that means should be found to obviate avoidable references to State finance departments in matters of programme management at State and local levels.

Further, it has often been pointed out that there has been much emphasis, in this country, on a single, simple, effective method which will catch the imagination of the people. First, it was the rhythm method; then diaphragm and jelly, and foam tablets, then sterilization and IUCD—(the oral pill is the coming favourite). Some States concentrated on sterilization and few others on IUCD. Despite a warning by experts of the futility of the *single method approach,* it continues to hold sway in the family planning programmes in the States. At the Central Government level, the official policy is to advocate what is known as the *cafeteria approach;* in which there is a great psychological advantage in offering people a *choice* instead of *pushing* the method which *we* consider the best. But this policy has been honoured more in the breach than in the observance. This is so because, while family planning is a centrally-sponsored programme with major financial assistance from the Central Government, the responsibility for implementation is with the States. Besides, while the population problem has always been considered as one of the biggest problems facing this country, none of the States has made an issue out of this problem. Critical observers have noted that the political and economic considerations have dominated the scene while hardly any attempt has been made in the family planning policy to carry home to the people of each State that it is a problem which faces their own State. This is an important area of research in the field of Centre-State relations that has so far remained neglected. The Second U.N. Mission has also noted the

need for over-all co-ordination of activities at Centre and State levels and of the interchange of research and evaluation findings.

ISSUES

17. Is the underutilization of funds by the States due to absence of sufficient programme activities, or due to absence of personnel, or merely due to the absence of drive and initiative on the part of the workers or due to red-tape and official procedures?
18. What is the kind of machinery to be developed for inter as also intra-departmental consultations at the Centre and State levels for coping with these problems?
19. Experiences with developing countries have shown that neither sterilization nor any method of contraception will be widely practised without *motivation*. If this is true, what needs to be done in regard to our "preoccupation with methods"—specially in States?
20. Should the States also adopt the policy resolutions in their respective legislatures?

Differential Approach

The revised programme and policy places great emphasis on community education as a means towards the adoption of family planning practices rather than on the establishment of clinics. The "reorganised" or the "extended" family planning programme has three operational goals for achieving the basic objective of reducing the birth rate; (*a*) group acceptance of a small-sized family, (*b*) personal knowledge about family planning methods, and (*c*) ready availability of supplies and services. To achieve this, individual approach has been much emphasized in the past. Now there is a shift to the other extreme in emphasizing the mass approach. In a mass programme, it is essential to set targets for achievement. But it should be remembered that targets are a means to an end and not an end in themselves. Over-emphasis on the achievement of the targets without regard to the local difficulties which the field workers experience and indiscriminate pressure on the field staff to achieve the targets can lead to malpractices. There are already indications of monetary incentives being misused and of fake cases or ineligible cases being operated or even repeated at some centres. Operations performed on such persons may help reaching the target without achieving the purpose. It is therefore necessary to use the targets flexibly and not insist on mechanical adherence in achieving them. Similarly, different targets should be set for different sections of the population, as well as for different areas in the country, bearing in mind the degree of motivation and rate of fertility among these differential groups.

Closely related to this is an instance of small family norm being advocated under the current policy. The development of such a norm

rests firmly on modern urban attitudes of a literate society which is developed both industrially and materially. To impose this value on an illiterate, ignorant, poor, agrarian society on marginal subsistence level where a surplus of fresh human stock is the only tangible capital, is to say the least, a himalayan task. Without corresponding and supportive changes in socio-economic structure, it is well-nigh impossible to secure wide acceptance of the small family norm. And for them varying nature of groups too, differential policies or at least different emphases in the approach will have to be envisaged.

There is yet another alarming situation that calls for an immediate correct perspective. Fears are often expressed that family planning is confined largely to urban areas and there too, it is resorted to by well-to-do and educated families. It is also said that contraception is practised by the majority community and some minority communities try to keep away from it. The point is generally made that the family planning, as it is considered now, would give rise to serious imbalances in the quality and texture of the population's composition. While it is agreed that there is no evidence of organised opposition to the programme, there seems to be some veiled suspicion and latent hostility which need to be examined and call for measures to overcome them. The fear of numerical loss of political weightage, or the fear of domination by other numerically superior groups tend to promote apathy and resistance to family planning and these issues ought to be handled with tact and understanding.

Unfortunately, the paucity of reliable information and studies continues in regard to the "strategic group" in the community : namely, political decision makers and administrators, employer's and employees' organisations and the medical and nursing professions. These groups need to be analysed and their attitudes described. Similarly, information will have to be obtained also on the major subcultural groups within a system such as castes and class, the extended families, nuclear families both within the extended family and as an independent unit, religious and, finally, peer groups. A systematic analysis along these sub-parameters may hopefully necessitate differential approach.

Issues

21. What should be the basis and procedure for identifying different areas-sub-cultural groups-religious groups, etc., and to assess their attitudes toward family planning, its policies and their level of adoption?
22. How do we integrate differential approaches to differences in the attitude and level of adoption of these sub-groups without bringing much complexities in the administration of differential approaches?
23. Can we work out details of an organisational pattern at central,

regional, district and local levels to cover three main areas in each, *viz.*, (*a*) Programme and Policy, (*b*) Training, and (*c*) Research?

Social Aspects

The family planning programme is constantly reviewed, assessed, improved and changed specially because it deals with human behaviour and needs which also change. The acceptance of a policy should mean clear statement as to the size of the population to which the nation can be and is in fact committed. Programmes on the essential components of the people's life will then be more meaningful. In other words, success of any social endeavour, therefore, depends much on the human response to it. Unfortunately, little notice has been taken of the traditional structure of society within which any project of social change, reform or reconstruction has to function. Barriers and resistances to family planning or even new values like age of marriage, the small family norm, women's employment in the context of family planning or even attitude to abortion are embedded in the rock of tradition and sometimes superstition.

Similarly, the way in which family size and structure influence the provision of educational and health services and housing has been considered by many social scientists. It has been evidenced that in societies where families are large and where large proportions of the population are of school-going age, there must be a heavy investment in educational and health services, associated with child-bearing and child care. In societies of low fertility, the educational burden is lower and the major health expenditure is on old people. The working force of fertile societies bears a heavier load than that of less fertile societies and this position is aggravated by the fact that the output per worker is much higher in those societies with low fertility. Likewise, housing needs of a community are closely linked to the size of family and changes in its members. The cycle of variation in family size, with at some stage several children, makes heavy demands for dwelling units with adequate numbers of rooms. This demand is hardly ever met by the supply. Large families will ultimately mean a marked rise in population, where mortality control is improving with further demands for housing. Similarly, the National Sample Survey has shown that fertility decreased with increase in per capita household expenditure. Evidence is also available that young people are very ill-informed of the most elementary demographic question and are totally ignorant of measures taken to control fertility. In fact, the main focus of the family planning programme should be to bring about behavioural changes so as to moderate fertility and establish the small family norm. But this involves many biological, social and psychological factors and these areas are more amenable to community or voluntary action. Its precise aim should be to integrate, through education and information, the idea of family limitation within the

existing attitudes, values, and goals of the people, and the target should not be only the married couples who do not want any more children but should also include girls and boys not yet married and even the married women wanting more children.

Similarly, if the communication and motivation are of great importance in carrying the message of family planning to the hundred million couples who, according to the present population figures, must be motivated to plan families, they should not at all be neglected. The crux of the problem is that if family planning remains a private planning, it eschews any societal control over motivation. If it merely furnishes the means, and, among possible means, only the most *desirable*, cheap, and easy ones, it might result in a failure to recognise the role of motivation. A number of studies in India have revealed that, while a large number of people have expressed an acceptance of family planning , and a desire to practise it, only a small minority in fact took any step to limit the family size. And, even this limited response came after intensive educational effort, utilizing the individual and group approaches. If this is the case in intensive research-cum-action programmes, one can imagine the result in extensive mass campaigns. In fact, there has hardly been any serious research on motivation among the large number of studies on family planning. This gap in our knowledge seriously affects implementation. There are some who brush aside any reference to the problem of motivation as of little significance. The field has also not attracted specialists in motivation and human behaviour, such as social and clinical psychologists. While motivation and communication have haunted research and discussions in recent years, actual studies have focussed only on communication. The field is also concerned with counteracting rumours and mis-information about family planning which unfortunately gains more rapid circulation in the community than correct information. Even motivation through direct face-to-face contact by extension education can have limited impact, if carried on by only *paid* agents. The various incentives have to be designed very carefully in country, ridden with poverty and already groaning under various economic burdens right from the level of the nation to that of the individual average householder. Changes basic enough to affect motivation for having children would be changes in the structure of the family, in the position of women, and in the sexual mores. One would *also* have to *feel* the necessity of asking why women desire so many children and how this desire can be influenced. Taking "mass communication" as the solution to the motivation problem would mean ignoring the power and complexity of social life.

As it is, reliance on family planning allows people to feel that something is being done about the population problem without the need for painful social changes. To alter a social system so as to regulate births in accord with the demands of the collective welfare would require adequate

provision for social welfare services, social legislation and social policy measures, and social reform measures. The programme should not merely be eclectic, popularising contraceptive methods which will ensure the success of family planning, but it should also aim at the effectiveness of our educational policy, of employment policy, industrial policy, of housing policy and in general of our economic policy. A large number of economic, social, legal, administrative and even constitutional measures have been contemplated; however, they are yet to be included in a broad-based policy for implementation.

Evidence is also available that high fertility and its consequence, rapid population increase, are closely linked to many of the economic, social welfare, health and other problems of development. Lower dependency ratios ; lower total costs for education, health, and welfare services, less pressure on medical personnel and health facilities, lower overall requirements for food, housing, and consumer goods; less pressure for the creation of new jobs; less rapid urban growth ; higher rural levels of living ; fewer maternal deaths; better health for children ; fewer abortions—these are some of the direct benefits that might be expected from lowered fertility achievable through integrated efforts.

Issues

24. In what ways have people responded to new values in the context of family planning ? How can they be integrated and boosted ?
25. Negative values, barriers and resistances to family planning are either developing fast or being overcome at a slow pace. What newer techniques can we introduce in the programme to overcome them ?
26. Should the population education be induced in the educational system immediately or gradually ?
27. What precisely is the audience's awareness and effect attributable to the existing mass-media and communication programmes ? Have we identified the separate effects of source, content, characteristics of audiences, and the method of mass media ?
28. Is it viable to devise a communication programme to address its messages to different audiences, and is it possible to have a programme for each audience ?
29. What are the modifications, necessary in the mass communication campaign so that it must be sensitive to local needs, local culture and local problems ?
30. It is said that "mass-communication" and "motivation" are too much overlapping in the existing programme. Do we need recognising a distinction between the two ?
31. A successful motivational technique is that any programme must continuously strive for variety. What are the varieties which need to be introduced in the family planning programme ?

32. Is it agreed that high motivation, and not a particular family planning method, is the cause of decline in the birth rate ?
33. What are the economic and social factors which can influence the motivation most so as to incorporate them in the policy ?
34. What is the role of social welfare work in the programme ? What is the impact which the social welfare services have made on the programme ?
35. What are the social reforms and social legislative measures that need to be immediately taken up and incorporated into the policy for expeditious implementation of the programme ?

Administrative Aspects

Several field studies and administrative assessments of the working of the programme, including the U.N. Mission Report and the Report of the Programme Evaluation Organization of the Planning Commission, had indicated that, under the first two plans, the government had not been successful in lowering the national birth rate. According to several critics, the true explanation for slow progress must be found, not in money (of which there was no shortage—rather many States did not utilise it fully); nor in trained personnel (of which the shortage could be managed) ; but it was due to the magnitude and the unprecedented nature of the task; the necessity to learn, by trial and error, the right thing to do and the right way of doing it. The Director's (Family Planning) Report 1962-63 attributed the reasons for this "slow progreess" to the clinic-oriented approach which included individual contacts with every married woman within the geographical jurisdiction of a clinic; this was a method of "low efficiency" since only a small proportion of the total population could be covered. The report also referred to the "female bias" in the programme which focussed exclusively on women and neglected the men.

It is to be considered how far all the lessons we have learnt in implementing the new reorganised programme would be helpful to us for the future.

Several observers have noticed that the implementors have failed to recognise the health or medical bias in the programme, and there has been an over-emphasis on a single method. The failure to recognise this would not be a matter of concern, but for the fact that these defects continue even now in the reorganised new programme of family planning. That it was the medical dominance of the field which resulted in the adoption of the clinical model and the female bias in the programme, was very well brought out long back. Besides, the P.E.O. of Planning Commission also reported against the use of surplus personnel from the malaria eradication programme in family planning as they may not be suited, by aptitude or experience, for family planning work. Many observers have questioned : Are

the medical personnel equipped to give the right type of leadership in a programme of *community education* on a mass scale ? Freeman has also drawn attention to the 'medical reluctance to build up responsibility among other types of workers and among the public for informational and supply-distribution aspects which has also been a serious barrier at times." Since the population problem is broadly connected with the social and economic systems, many observers have also questioned why the Ministry of Health should be the source of population policy. Why not Ministries of Education, Community Development, Social Welfare and the like ?

The administrative decisions in regard to target setting have also been changing fast. In determining regional components and time-targets, many specialists have suggested, that various human factors have to be borne in mind. For example, it has been noted that acceptance rates were influenced by urban or rural residence, literacy rates and several indicators of social and economic status. It has also been recognised that a satisfied user helped to spread the programme and that some advantage was to be gained by giving greater weightage to areas where the response was likely to be most favourable.

Similarly, after formulating the plan, the staff requirements or man-power needs become a key problem. An important problem sometimes is raised with regard to technical and other personnel. Should they concentrate on family planning work or be involved also in other programmes or services ? It is a commonplace observation that the specialization of medical personnel is being mostly utilized for administration in most districts and blocks. Added to this is also the preference for "unipurpose" or "multi-purpose" workers in the programme which need to be decided.

Likewise, there are other aspects of training, supplies, transport, budgeting, cooperation from non-governmental agencies, research and implementation for which an effective evaluation machinery is required. If evaluation is taken as an applied study to get results for a certain input, it has to serve the administrator by : (*a*) detecting problems of implementation for him to correct ; (*b*) providing information needed for further planning; and (*c*) providing information he needs in obtaining further financial and other support.

The U.N. Mission has recently made several recommendations on long-range administrative planning and institutional development for adapting the programme to changing conditions, and the need to clearly define responsibility for managing the programme at the Centre and in the States. It has also recommended that the relationship between the Federal and State Governments should be viewed as dynamic, meriting constant study with a view to effect timely changes and has mainly invited the attention to the fact that much of the family planning personnel are regarded as "temporary" which causes problems. As such, the programme should be

regarded as "permanent" both at the State as well as at the Central levels as it has far-reaching effects on recruitment, and impairs relations between "permanent" and "temporary" personnel, and, reportedly in some States, limits the authority of "temporary" personnel. Further, key management posts in family planning need to be filled by personnel who are professionally trained in health administration, health education, motivation and communication, and other relevant skills. The Mission has also highly recommended that since family planning involves behavioural as well as medical factors, trained non-medical staff (social scientists, social workers) with higher academic qualifications and administrative experience, should be increasingly employed in the programme for planning and implementation. Such an arrangement would help free medical personnel for technical work and, at the same time, improve administrative efficiency.

Similarly, it has been noted that voluntary organisations, such as the Family Planning Association of India, the Indian Medical Association, the Population Council of India, are doing pioneering and recommendable services to family planning in this country. The participation of such organisations is highly commendable, and, in fact, in many areas, the success of the programme would not be possible but for their cooperation. It may also be worthwhile to make a comparative study of all such organisations functioning in urban areas to achieve a division of labour that will maximise programme efficiency.

Issues

36. Is a medical background a necessary qualification for the top leadership ?
37. Should a family planning programme be conducted exclusively or primarily by the Health Department ?
38. Are there advantages to be gained by using multi-purpose workers ?
39. What is an appropriate combination of social scientists, medical personnel and administrators in the staffing of a family planning programme ?
40. Should monetary incentives be given ?
41. Should the training of workers be entirely job-oriented ?
42. Should the rural areas with their greater population be tackled first, or should the critical targets be those which are considered to be more receptive to new ideas ?
43. Should a family planning programme concentrate its manpower resources and services in a few places where the probabilities of success are greater ?
44. What is the relative emphasis to be given to the utilization of mass media *vis-a-vis* carrying out face-to-face education by health educators and field workers ?

45. What should be the most effective personnel policy for non-medical personnel to encourage their job commitment and efficiency ?
46. Should the administrative system be flexible or fixed ?
47. What are the ways and means to be devised for increased State's involvement in policy adoption and implementation ?
48. What should be the precise role of financial authorities, especially of State Finance Departments, in clearing out the funds ?
49. What are the effective measures to be taken to utilise the research findings at the Central and State levels and feed them into the programme ?
50. How can the voluntary agencies be maximally involved in the programme ? What specific responsibilities would they like to share with the Government ?

Conclusion

Clearly, therefore, the task of our policy is to develop attractive substitutes for family interests, so as to avoid having to turn to hardship as a corrective. It can never be gainsaid that population is an important variable of concern to development planning. It is as amenable to planned change and control as other variables that planners work with. Resources and effort devoted to population planning and programming—including fertility limitation—will pay off more handsomely in economic return than resources devoted to more conventional aspects of development. We do not have to be the helpless victims of our reproductive capacities. We have demonstrated our ability to postpone death for large numbers of our people. That success now confronts us with the challenge to practise equally well the postponement and control of births by means of an effective, dynamic policy envisaging larger socio-economic variables.

URBAN LOCAL BODIES AND THE PROGRAMME OF FAMILY PLANNING

PROF. DEVA RAJ*

The Ministry of Health and Family Planning of the Government of India have been deeply conscious of the role of urban local bodies in the implementation of the Family Planning Programme. The Department had already taken some steps for involving them in the programme but the results had not been satisfactory. The question was brought up before the Central Council of Local Self-Government at its meeting held at Udaipur in April, 1966. A Committee was set up by the Council, which produced a quick report making important recommendations to enable municipal authorities to participate actively in the work of Family Planning. The Government accepted its main recommendations about a special pattern of assistance for urban local bodies and issued orders in October-November, 1966, laying down pattern of assistance for four types of urban units, to meet the needs of towns with smaller populations as well, *viz.*

(*i*) for population upto 10,000
(*ii*) for population between 10,000 and 25,000
(*iii*) for population between 25,000 to 40,000
(*iv*) for population around 50,000.

This was expected to enable urban centres being established for the above population groups, irrespective of the general pattern of a unit for 50,000. The ceilings laid down were meant to be indicative of the level of staff to be appointed and the State Governments were given the freedom to make necessary minor adjustments in the financial limits prescribed. The larger cities and corporations were also to be allowed to start family planning bureaux and a pattern of assistance was laid down for population between 2 to 5 lakhs (Type I), between 5 and 7.5 lakhs (Type II) and those with high populations (Type III) around ten lakhs. It was hoped that the State Governments would take early steps to ensure the participation of local bodies in a more active and vigorous manner. The coordination of work between the corporations and the State machinery was to be made at the level of the State Planning Bureaux and for other local bodies at the

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level of the District Family Planning Bureau. The urban local bodies were to be represented in the State Family Planning or the District Family Planning Coordination Committees.

Nevertheless, the progress towards involvement of local bodies and the establishment of urban family planning centres under their auspices was halting. The matter was reviewed at a meeting of State Family Planning Officers in March 1967 and it was reported that not many local bodies and *panchayats* had availed of the assistance offered in this respect. Considering the urgency for implementation of the Family Planning Programme, the Government of India requested the State Governments in May, 1967 that "necessary guidance and help may be provided to the local bodies and *panchayats,* particularly smaller ones, to enable them to establish such centres as quickly as possible. If, however, they are unable to establish these urban units by the end of September, 1967, the State Governments may themselves undertake to establish family welfare planning centres in such places."

Family planning units and the necessary urban local authorities were in fact being established for some time depending upon the initiative of the local authorities concerned, their commitment to medical and health activities, and the contacts of their officials and non-officials with the State Government. By the beginning of 1968, out of the total of 1650 urban centres established in the country, the urban local bodies had only 292 centres (Table 1.)

As many as 392 were being run under voluntary auspices and the balance of 966 were under Government auspices.

It is significant to note that it is precisely where urban local bodies are relatively strong and the State Governments have had working arrangements with them that municipal authorities were allocated the task of managing family planning units. By and large, local authorities, particularly in the urban areas, are not looked upon, as in the West, as the local agencies for implementation and execution of the national health and social welfare programmes. The State Medical and Health Directorates have a long-standing tradition of apathy towards municipal councils and prefer to establish preventive and curative services under their direct control and administration. It is not surprising, therefore, that the orders of the Department of Family Planning did not often percolate down to the local bodies' level. In the course of seminars of representatives of urban local bodies organised by the Department of Health, in 1967 in Bangalore and at Hyderabad in 1968, it was stated that many local bodies were ignorant of such orders.

A discouraging factor has been the weak financial position, particularly of smaller and medium size municipalities, coupled with the inordinate delays in the release of grants. The difficulty has been that urban local bodies have been looked upon and treated as any other private or

voluntary organisation with the added stigma of administrative inefficiency, which dominates the thinking of Government departments. It is hardly appreciated that they are Governments at their own level, subject to a regular system of control, supervision and audit by State Governments. The submission of audited accounts by these local bodies would normally take 2 or 3 years, while registered societies can produce an audit certificate by private auditors. The Government of India had to issue instructions for release of grants on receipt of statement of accounts certified by the Chief Accounts Officer or the Chief Executive of the local body, subject to final adjustment when the accounts are audited. Even so, payments of continuing grants have not been a smooth affair. The seminars of elected representatives of municipal councils referred to above, complained that grants were not being received in proper time, due to administrative and procedural difficulties.

TABLE 1

State	Total Urban Centres established	Under Urban Local Bodies
Andhra Pradesh	181	13
Assam	28	—
Bihar	87	2
Gujarat	74	14
Haryana	55	7
Jammu and Kashmir	5	—
Kerala	33	4
Madhya Pradesh	190	3
Maharashtra	166	72
Mysore	57	12
Orissa	52	12
Punjab	90	31
Rajasthan	72	—
Tamil Nadu	61	41
Uttar Pradesh	144	38
West Bengal	148	18
Delhi	54	25
Other Union Territories	34	—
Central Government Institutions	119	—
Total	1650	292

One of the factors contributing to the halting progress in involving the urban local bodies in the implementation of the programme has been

that many of the medium size local bodies came into the field rather late. There have been cases where the municipal councils have pressed for establishment of a Family Planning Centre under their auspices, but the request could not be acceded to as the city was already 'saturated' having the permissible number of centres on the basis of its population. One of the cities even worked successfully as sub-Centre with some support of the Government-run urban unit. Another solution would be the transfer of at least one of the centres to municipal auspices but any proposal for change of management presents many a difficulty.

While the schematic approach to the involvement of urban local bodies did not make much headway for a variety of reasons, there was practically no attempt to adopt what may be described as the extension approach to secure the cooperation and participation of the municipal authorities in the furtherance of the Family Planning programme. The municipal councils not only have local leadership drawn from various geographical, social and functional sectors of the town, but they represent the corporate urban community, with statutory embodiment of the local will. Apart from this, they have ready-made field organisations reaching every household with its environmental services and responsibility for registration of births and full vaccination coverage. They have also dispensaries and maternity centres, which could with a small supplementary aid in terms of equipment and supplies, be exploited for approaching eligible couples.

It would be interesting to take note of some of the recommendations of the seminars of local bodies' representatives in this regard. They recommended that all State Governments must insist that every municipality take active part in the implementation of the family planning work and that all municipal and public health staff must be given training at the Regional Family Planning Training Centres. Their agency could be utilised for distribution of contraceptives. It was also suggested that the goodwill of the entire council of the local body should be mobilised and councillors given orientation in family planning. They could help in the formation of ward committees and bringing up local leadership for overcoming local prejudices and social and religious barriers. There should be an automatic process of supply of literature to local bodies, who should be supported in setting up a health education unit and family planning information centres. They could even help in producing and printing educational materials in tune with local needs. It was also desired that priority be given to municipalities over other organisations in the matter of establishing Family Planning Centres.

In short, there is need for a fresh approach to the question of involvement of municipal bodies on the basis of their recognition as local arms of the Government and yet strongholds of local leadership. It must also be appreciated that municipalities are the field public health agencies in urban areas and this is their dominant function accounting for major part of their

expenditure along with education. Their interest in maternity services should be made full use of and the policy of integrated family and child health services should make it possible to subsidise and support maternity and child centres by the smaller municipalities in particular, with a commitment and orientation to the furtherance of the objectives of the Family Planning Programme.

SOCIAL ASPECTS OF FAMILY PLANNING

DR. B. K. ROY BURMAN*

Family Planning—an End or a Means

By usage, two terms, namely, family planning and population control have come to be considered to be practically synonymous in many countries, but conceptually they should be looked upon as discrete, though not always unrelated social phenomena.

At the family level, it was not uncommon even in the past to look upon limiting and phasing the size of the family, as a necessity, without any consciousness of its impact on the size of the population at the national level. Even today, there are many sparsely populated areas in the world, where population control at the national level is not a necessity; but it is conceivable that even in such countries, limiting and phasing the size of the family is considered as an ideal by a large section of the population. The practices for limiting the size of the population at the family level and policy-formulation for increasing the size of the population at the national level may go side by side. In fact, this is what the present writer observed in the Soviet Union. In Moscow or Leningrad, hardly any family is found with more than one or two children. On the other hand, he came across a poster, "It is good to have one child, but better to have two".

It is also theoretically possible for over-populated countries to reduce the size of the population, even without taking recourse to family planning measures, by encouraging migration of the surplus population. Admittedly in the context of the present world, the scope of such a method of checking the growth of population at the national level is extremely limited; but, even then for the sake of clarity of thought, such a possibility should not be ruled out.

It is not just as a matter of semantic exercise that it is suggested that family planning and population control should be considered as two discrete phenomena. Their dissociation from one another in our thinking habits, has cultural as well as operational implications.

When family planning is freed of the goal of limiting the population at the national level, it comes into focus as an end by itself. On the other hand, when family planning is projected as a necessity for keeping in check

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the growth of the population at the national level, it is primarily considered as a means and not as an end. It is quite possible that even when family planning is primarily looked upon as a means, it is also looked upon as an end. But it is to be appreciated that the strategy of motivating the population, for adopting the family planning measures would be different, when it is primarily looked upon as an end.

Family Planning as a System of Ideology

When family planning is looked upon as an ideal or as a way of life, it is to be assumed that it does not stand alone, but is part of a system of ideology. In other words, it would be associated with a number of other values and attitude orientations. Some empirical evidence in favour of this assumption is available. Malakar[1] (1959) has reported that husbands and wives who express more liberal views about marriages of their sons and daughters use contraceptives more frequently than those who disapprove any deviation from the tradition of arranged marriages. He has also found that there is a positive association between liberal attitude towards education and outdoor employment of daughters and acceptance of contraceptive devices.

There are, however, evidences to the contrary as well. An evaluation study carried out by the Programme Evaluation Organisation of the Planning Commission (P.E.O.) in 1964-65[2] tended to show that "the fatalistic orientation of the rural people did not appear to have stood in the way of adoption of family planning methods for the purpose of limiting the number of children. This also supports the view point that human behaviour and action may have both a rational and non-rational orientation. Therefore, new practices could be propagated without modifying directly the existing beliefs and values".

These two types of evidences call for further studies to resolve the controversy. It is quite possible that, while in a particular structural set-up, either of the points of view may be valid, it may not have a general validity. Besides, there might be cross-cultural differences in family size norms, irrespective of fatalistic attitude or otherwise of the rural people. The P.E.O. does not appear to have examined this aspect of the question.

Harmonization of the Programme of Family Planning with the Cultural Orientation of the Community

Irrespective of the existence or otherwise of a coherent system of ideology, conducive to the adoption of family planning as a way of life, it

[1]C. R. Malakar, *Conflicting Value Among Social Classes in Relation to Fertility Control*, 4th Session, Indian Sociological Conference, 1959.

[2]*Family Planning Programme in India—An Evaluation*, Programme Evaluation Organisation, Government of India, 1970.

is important to harmonise the family planning programme (when it is adopted in national interest) with the cultural orientation of the community. If the ideology of family planning is in conformity with the cultural orientation, the operational aspect of the programme (including the technical and organisational aspects), rather than the ideological aspect, would become the primary concern of all, interested in promoting the programme. If, on the other hand, the ideology of family planning is not in conformity with the cultural orientation of the community, the task of human engineering in respect of this programme would imply, a transvaluation of values—a sort of philosophical revolution. This is an uphill task and a national elite is morally justified to undertake it, only when the survival of the community is at stake.

Two Levels of Orientation

For determining whether the ideology of limiting and phasing the size of the family is in conformity with the orientation of the culture or not, it is necessary to examine the orientation at two levels, namely, basic level and induced level.

Basic Orientation : (a) Global Dimension : There is a point of view that the act of procreation is related to deep psychological cravings of men and women and structural needs of the society and that non-recognition of this basic fact had led some demographers to the making of wrong projections. As noted by Freedman[3], "Prewar writing about the urban family emphasized its loss of functions to other specialized institutions and used the decline in family size as an important index of this trend. Projections to a situation with very low fertility and with many intentionally childless families were a logical extension of this basic orientation. Special social incentives to child-bearing were widely discussed as a means to achieve the reproductive needs of the society in view of the presumed lack of motivation for having children. In the postwar period, there has been a re-discovery by sociologists of the persistent strength of primary groups, and specially of the family".

In view of the assumed psychological needs and structural imperatives of the society, it is suggested by many that the practice of permanently impairing procreative capacities, through vasectomy and sterilisation, is fraught with the danger of creating a widespread problem of mental health and marital maladjustment. There are at present a number of studies of the after-effects of vasectomy and tubectomy; but the evidence does not warrant any conclusion.

The type of basic orientation indicated here, if it is substantiated by systematic research, would, however, be almost global in dimension and

[3]"The Sociology of Human Fertility", *Current Sociology,* Vol. X/XI No. 2, 1961-62, p. 36.

would be more related to the nature of man, than to any specific culture.

(*b*) *Culture Specific Dimension :* Among the elements of basic orientation which have bearing on the family planning programme and which are shared by the large majority of the Indian population, mention may be made of the fact that extended family in the normative sense and not necessarily in the sense of coresidential household is considered to be a value. Even in the context of urban societies, Freedman[4] has pointed out that increasing use of sample surveys and other techniques for studying normal families have provided evidence of the continuing importance of extended family along with nuclear family.

Induced Orientation : Where the desirability to have a large number of children is related to the fear of high mortality of children, it can be stated as an induced orientation.

Operational Implications of the Recognition of the Cultural Orientations

(*a*) *With Reference to Extended Family as Basic Orientation of Culture* : In so far as extended family is considered to be basic orientation of culture of the overwhelming majority of the Indian population, it is obvious that if family planning is to be firmly incorporated as a way of life, its ethos should not be in a state of perpetual disharmony with the ethos of extended family. This proposition should, however, not be interpreted to mean that the ethos of extended family and the ethos of family planning are in a static condition or that their mutual relationship always remains in a static condition. In fact, there is reason to believe that dynamic adjustments are taking place in all of these. In the classical extended families, most frequently the emphasis was on parental authority, geographical propinquity, mutual assistance among the members of the kingroup and exclusiveness in respect of the larger society. This pattern has undergone considerable modifications in various societies. Litwark[5] has reported in respect of the modified extended family of the west that it differs from past extended families in that it does not require geographical propinquity, occupational homogeneity, or integration and there are no strict authority relations, but equalitarian ones. Family relations differ from those of isolated nuclear family in that significant aid is provided to nuclear families, although this aid is less related to standard of living, (housing, illness, leisure pursuits) than to occupational appointments or promotions. Other types of variations in the ethos of extended family can be visualised with reference to specific variables. For instance, with reference to female based families, Gough[6] has stated that

[4]Ronald Freedman, "The Sociology of Human Fertility", *Current Sociology*, Vol. X/XI, No. 2, 1961-62, p. 36.

[5]E. Litwark, "Modified Extended Family", *American Sociological Review*, June, 1960.

[6]Schneider D. Mand Gough, Kathleen (*eds.*), *Matrilineal Kinship*, University of California Press, 1961.

with the exception of highly productive matri-states, the higher the productivity of the society, the more extensive are controls exercised by descent group heads over the resources, distribution of goods, labour and personal lives of members. In large states, the lower the caste, the greater is the area of control assumed by higher economic and government authorities of the state; consequently, such controls are lost to descent groups. It is obvious from the above, that ethos of extended family is not something which is not immutable or liable to be modified in response to extraneous factors.

Ethos of Family Planning and Shifts in the Same

As regards shifts, in the ethos of family planning, it is to be noted that some these shifts are intrinsic in nature. The constituent elements of the ethos exist at primary and secondary levels

Primary Level : The primary level again may be further divided into individual, conjugal and family sub-levels.

Individual Sub-level : At the individual sub-level either of the partners may be oriented towards family planning through socially irresponsible egoism or through socially responsible individualism. The person concerned may decide to accept or reject devices for controlling procreation, in response to one's own mental disposition only, without consideration for the disposition of even the other partner of the conjugal pair. In such a case it is socially irresponsible egoism. On the other hand, though the individual concerned may look upon the question as a matter of personal decision, he or she is not oblivious of the commitments to the society at various levels, including the family sub-level. Such a case would come under the category of socially irresponsible individualism. At the conjugal level, Misra[7] has reported that the greater the communication between the spouses, the greater is the likelihood of their approval of birth control and also greater is the probability of their limiting the family size. Here the relevant factors are :

(*a*) Flow and direction of communication; to wit, it may originate from either of the partners;

(*b*) Nature and intensity of the communications. For instance, it may be authoritarian, democratic or mutually confronting in nature, with varying degrees of intensity and frequency.

More studies are required to find out the correlation between the nature of communication at the conjugal sub-level and the acceptance of family planning as a way of life, so that the constituent elements of the ethos of family planning at that sub-level may be determined.

Family Sub-level : As regards the family sub-level, *prima facie* it

[7]B. D. Misra, "A Comparison of Husband's and Wives' Attitude towards Family Planning", *Journal of Family Welfare*, June, 1966.

appears that positive orientation towards family planning implies readiness to subject the satisfaction of sex to the consideration of the welfare of the progeny.

Secondary Level : Coming over to the secondary level, it is difficult to say whether any ethos concerning family planning exists at that level, as a persistent social fact. It appears that a moral drive relating to family planning comes into existence at caste or tribe or national levels as a short lived phenomenon, only in special circumstances, to wit, during a renaissance type of social movement, when creative participation to build up a particular way of life for the community as a whole, is by itself looked upon as a volume.

Renaissance is a process of individualisation of the collective by surcharging the collectivity with the values of freedom and collectivisation of the individuals, by projecting to them the symbols and needs of the collective, as moral categories, rather than as imperatives legitimised by the established authorities, wielding coercive powers. Essentially, the ethos of renaissance subsumes the ethos of modified extended family, as described earlier. It is easy to perceive that there is no reason, why the ethos of family planning as it is, or with certain modifications, cannot be harmonised with this. But all the same, the task of effecting the harmony through planned actions may remain to be undertaken.[8]

Operational Problems Relating to Included Cultural Orientation Relating to Fear of Infant Mortality

As stated earlier, the stimulus for this induced orientation appears to be the lurking fear of infant mortality. It would, therefore, appear that with the removal of the stimulus, the orientation also would undergo a change. In other words, with the reduction in infant mortality, the desire to procreate large number of children will be reduced to the corresponding extent. But such straight relationship hardly ever exists in society. Certain other questions, for instance the question of learning and unlearning culture traits, tendency of culture traits to cluster together and hold on together, organisation of social action and so on, get entangled in such matters. In respect of specific communities, further studies will have to be undertaken to establish the pattern of co-variation in the reduction of infant mortality and in the desire to procreate large number of children. In the meantime, in a general way, it may be stated that, in spite of reduction in infant mortality, desire to procreate large number of children may continue, because of :

(*a*) perception lag at the level of conation though there may be

[8]B. K. Roy Burman, "Family Planning from the Point of View of Cultural Anthropology", *The Indian Journal of Social Work*, Vol. XXX, No. 4, January 1970.

perception at the level of cognition.

(*b*) capacity of linked traits, like alterations in the intra-family relationships during pre-natal and post-natal periods, reiteration and reinforcement of the mutual relations of husband and wife on the occasion of birth of a child and so on, to provide intense satisfaction, independent of the satisfaction of having a child, and

(*c*) Influence of vested interests that have grown around the institution of birth of a child. Among the last category of factors, mention may be made of the functionaries of temples, specially renowned for enhancing fertility of women, astrologers, mendicants, indigenous midwives and old female relatives, whose usefulness in the family goes up during the birth of a child.

It is obvious from the above, that, even when desire to procreate large number of children is related to induced orientation, removal of the original stimulus is not likely to bring in change of attitude in a mechanical manner. The task of human engineering will still remain to be undertaken, as in the case of harmonising the ethos of family planning with the ethos of extended family.

There are certain structural elements which may facilitate the task of social engineering. One of them is an apparent ambivalence relating to procreation; the other is the probability of existence of a family size norm.

Ambivalence Relating to Birth of Children

It appears that many communities in India suffer from, what may be called, a mild form of cultural ambivalence, in matters relating to birth of children. On the one hand, there is the assignment of high value to the multiplication of children. The ancient maxim, *putrarthe krivate bharya* (the purpose of having a wife is to have male progeny) is well known. Among the Totos—a tiny tribe in the borders of West Bengal and Bhutan, marriage is solemnised only after conception. Among many communities, a barren woman or a man without issue is considered to be inauspicious. It also appears that among many communities, a woman with high fecundity enjoys a high prestige. But, at the same time, among most of the people of India, celibacy is considered to be a supreme value. Besides, it is to be noted that in case of procreation, there is generally preference for child of one sex only, namely, the male sex. It is not unoften that birth of a daughter castes a shadow of gloom in a family. In many parts of India, birth of three daughters in succession is considered to be a sign of bad luck. Practice of female infanticide prevailed even among advanced communities like the Lushais, practice of male and female infanticide, to limit the size of the family to the resource position, has been reported by early ethnographers.

It is quite possible that the cultural ambivalence indicated above is more apparent than real; and that coming down to the level of individuals

no ambivalence really exists. The conflicting values and attitudes may reflect segmental cultures. The segments may be based on regional or other social entities. The segments may even be based on social stratification or sex differentiation.

Whatever may be the structural implication of the ambivalence described above, it is obvious that among some section of the population at least, there is a traditional need disposition to limit the size of family.

Family Size Norm

That a large number of children are not always desired for their own sake can be adduced from the fact that side by side with this desire, there is, at least in some areas, a manifest concept of optimum size of household, matching the resources of the household. For instance, the proverbial ideal among the peasants of Punjab is "God give me a family of optimum size, consisting of one daughter and two daughters-in-law".

It is, however, difficult to say whether optimum size of household has crystallised into a cultural pattern among all the communities in India. In fact among many communities, specially those engaged in agriculture and extraction of natural resources, addition of a child, does, not only mean extra mouth to feed, but, also extra hands to work. But, at the same time, it cannot be denied that among many people, specially among those who are engaged in secondary or tertiary sectors of economy, a poor man procreating children year after year, is considered to be an unwise man.

M. V. Raman[9] has reported that a clear formulation of social class differential in family size preferences in India is rather difficult, in view of the vagaries in the existing information, presumably due to regional and other effects. Some of the fertility investigations have indicated that with the rise in the socio-economic status, the number of children desired also increases. Responses of women in Calcutta show that under 'existing' conditions they would prefer two children, while under 'ideal' conditions they would prefer four. This variation in attitude has operational significance for the family planning programme, particularly in the context of the expected improvement in the economic situation, consequent upon the operation of development plans.

There are, however, conflicting results, obtained from other studies. For instance, in Kanpur,[10] an industrial city in Uttar Pradesh, while there was no difference in the number of children desired by illiterate and primary educated women, the number desired was less in the case of secondary and college educated women. In Bangalore city,[11] high educational level and

[9]M. V. Raman, *Attitude Towards Family Size and Fertility Control in India*, World Population Conference, Belgrade, 1966.

[10]Kanpur City Survey.

[11]S. Raghavachari, *Fertility Among Different Socio-economic Categories*, 4th Annual Conference, Indian Sociological Association, 1959

high economic status were found to be correlated with the desire to have a small family.

In view of the conflicting nature of the observations from different parts of the country, a well thought out investigation at the national level is necessary to determine whether a culturally defined family size norm is in existence cutting across economic status differences and other variables. Besides, it is necessary to determine the norms about intermediate variables like: (*a*) age of marriage, (*b*) proportion of women entering into sexual union, (*c*) amount of reproductive period spent after or between unions as a result of death, divorce, separation or desertion, (*d*) exposure to intercourse within unions, and (*e*) factors affecting gestation and successful parturition, as these will have bearings on the fertility rate of the community.[12]

But before these are examined, a brief notice would be taken of the fertility differentials in the different regions of the country.

Fertility Differentials

Jain[13] has drawn attention to the wide range of variation in the general fertility rate and marital fertility rate in the different states of the country. Both rates show the highest fertility in Assam and the lowest in Madras, when compared with the level in other states which did not differ much among themselves in this matter.

Summing up the indications of the studies carried out so far, Jain has expressed the opinion that the cause of Indian differential fertility will be found more in the socio-cultural fields than in the economic field. Some aspects of the socio-cultural fields, particularly those with psycho-dynamic implication have already been discussed. A few others would be examined here.

Age at Marriage

Judith Davis Blake[14] has recently advanced an interesting hypothesis that the customs requiring the elders to make arrangements for early marriages of their children are in part control mechanism inhibiting their latent desires for delay—desires based on the socially supported expectation of rewards for parenthood. Where the community does not check parental interest (or even implicitly encourages them) then control by elders can be a powerful influence leading to late marriage. It is only after a thorough psycho-social probe, that it can be stated whether this hypothesis has any validity universally or even in any particular culture. If its validity is established, it would certainly provide a new direction for the manipulation of

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[12]Ronald Freedman, "Sociology of Human Fertility", *Current Sociology*, Vol. X/XI, No. 2, 1961-62.

[13]S. P. Jain, *State Growth Rates and their Components.*
Ashish Bose, *Patterns of Population Change in India*, 1951-61 (ed.), 1967.

[14]Judith Davis Blake, *Parental Control, Delayed Marriage and Population Policies*, World Population Conference, Belgrade, 1965.

the communication media. At this stage, it is to be noted that there is a considerable variation among the religious groups in their ages at marriage. According to Driver[15] who had undertaken a study in Central India, at the one extreme are the wives in the Hindu group with a median of 14.0 years and at the other are the wives in "Other Religions" (Christians, Parsis, Sikhs and Jains) with a median of 18.6 years. In case of husbands also, the greatest difference occurs between Hindus and those of "Other Religions". Age at marriage also varies among the Hindus differentiated according to caste identity. Brahman and Maratha wives have medians of 16.9 and 16.0 years respectively, the Kunbi and Teli wives have medians of 17.7 and 12.6 years respectively.

Fertility with Reference to Age at Marriage

After analysing the NSS data for Madras, Kerala and Mysore, Nitai Chandra Das[16] has come to the conclusion that there might exist a critical line below which the postponement of marriage does not affect fertility.

As against this point of view, S. N. Agarwala[17] is of the view that late marriage appears to have a significant effect on the fertility of Indian women. Sovani[18] also is of the view that age at marriage affects age specific fertility, reduces childlessness, etc., indicating that marriage contracted at higher ages brings about a less fertile union. Driver[19] is of the view that the studies do not provide us with any clear-cut relationship between age at marriage and fertility.

Rural Urban Differences in Fertility

According to Davis,[20] an inverse ratio between city size and fertility level was apparent in the child-women ratios calculated from the 1931 Census of India. On analysis of India's fertility data, Robinson[21] reached two conclusions; "First, the large rural-urban fertility ratio differentials disclosed by earlier investigations have been diminishing over the last several decades; and second, only modest rural urban fertility ratio differentials exist, using the most recent age distributions particularly in terms of marital fertility ratio".

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[15]E. D. Driver, *Differential Fertility in Central India*, Princeton University Press, 1963.

[16]Nitai Chandra Das, *A Note on the Effect of Postponement of Marriage on Fertility*, World Population Conference, Belgrade, 1965.

[17]S. N. Agarwala, *Effect of Rise in Female Marriage Age on Birth Rate*. World Population Conference, Belgrade, 1965.

[18]N. V. Sovani, *Internal Migration and Future Trend of Population of India*, World Population Conference, Belgrade, 1965.

[19]E. D. Driver, *op. cit.*

[20]Kingsley Davis, *The Population of India and Pakistan*, 1951.

[21]Quoted by Concepcion.

Summing up the results of the various studies, Concepcion[22] has come to the conclusion that "most of the evidences available from other studies on differential fertility in India" show that urban fertility is no higher than rural fertility".

Occupation, Income and Fertility

The studies of Driver[23] reveal fertility differentials on the basis of occupation and income. But he finds that when the age difference of the married women are controlled, the difference in the range of fertility is much narrowed down.

Effect of Education on the Level of Fertility

The Mysore population study[24] has brought out that a high educational level and a high economic status are correlated with desire to have a small family in Bangalore city. On a comparative study of the fertility data available for 49 countries, Kumudini Dandekar[25] has found that the higher the level of education of persons, the smaller are the number of children born to them in those countries. Driver[26] has found that when couples are classified on the basis of the husband's educational achievement, considerable variation in fertility is evident. Studies by other scholars also reveal the same trend. But it is desirable to strike a note of caution. In a paper contributed to the World Population Conference 1965, Sadvokasova[27] has stated that a special study carried out in Soviet Union shows that with further growth of the national economy, the rise of cultural level and the provision of pre-school children's institutions in adequate numbers, the birth rate may rise somewhat in future. Though the mechanism of such rise, as described in the paper, has no direct relevance to the present conditions of India, a continuous observation of the trend is called for, particularly in the context of the green revolution.

Housing Condition as a Factor

Moni Nag[28] has pointed out that lack of adequate privacy due to overcrowding in the houses under the occupation of extended families may be a

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[22]M. B. Concepcion, *The Effect of Current Social and Economic Changes in the Developing Countries on Differential Fertility*, World Population Conference, Belgrade, 1965.

[23]E. D. Driver, *op. cit.*

[24]*The Mysore Population Study*, 1961, United Nations.

[25]Kumudini Dandekar, *Effect of Education on Fertiliy.* World Population Conference, Belgrade, 1965.

[26]E. D. Driver, *op. cit.*

[27]E. A. Sadvokasova, *Birth Control Measures and their Influence in Population Replacement*, World Population Conference, Belgrade, 1965.

[28]Moni Nag, *Family Type and Fertility*, World Population Conference, 1965, Belgrade.

factor for low fertility among them. There is, however, an opposite point of view, that lack of privacy in congested houses makes the adoption of family limitation practices difficult and thereby contributes to the high fertility rate. More empirical data are necessary for assessing the correct position.

Family Type as a Factor

Lorimer[29] is of the view that the whole cultural context in the extended families tends to be idealised and is likely to be conducive to high fertility. Davis[30] has enumerated a few causes why joint family is expected to be conducive to high birth rate. They are : (1) young mothers in joint families are more free to engage themselves in economic and other activities because their burden of child-rearing is shared by other members of the house-hold; (2) the children in joint families marry at a lower age because it is not necessary for a married couple in such a family to support themselves immediately after marriage; (3) religious and moral obligations to marry couples with kin solidarity are responsible for universal marriage in joint families; (5) the young bride in a joint family is a stranger and has a very low status until she gives birth to a baby and is therefore motivated to have a child as early as possible and in considerable number; (5) men in joint families are highly motivated to demand offspring and the blame against the barren women is very strong in these families.

After examining the available statistical data, Nag[31] has come to the conclusion that there is only meagre support in favour of the view that joint family is conducive to high fertility. Poti and Datta have found the lowest fertility in one generation joint family complex. Uma Guha has found that the number of children in joint family is less than that in simple families when women in all ages are considered.

In the light of the above data, Nag has suggested that it is necessary to investigate whether there are institutional or biological factors which effectively counteract the factors mentioned by Davis. In this connection, he has suggested that, along with others, variation in the normal frequency of coitus is one of the direct factors which may be responsible for variation of fertility level. The average coital frequency for simple families is likely to be consistently higher than that for joint families.

Caste and Community as Factors

On analysis of the results of a demographic survey of eight towns in Kerala, Mathen[32] has come to the conclusion that caste differences do not

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[29]Frank Lorimer, *Culture and Human Fertility*, U.N.G.S.C.O. 1954.

[30]Kingsley Davis, *op. cit.*

[31]Moni Nag, *op. cit.*

[32]K. K. Mathen, *The Impact of Family Planning Movement on the Indian Population*, World Population Conference, 1965, Belgrade.

influence the level of fertility. Driver[33], however, is of the view that there is a considerable range of fertility differential on the basis of caste. The studies of Saxena[34] also show a slight association between fertility and caste hierarcy. One of the important reasons for such association is that the upper caste groups more frequently tend to abstain from sexual intercourse on auspicious days. While the factors indicated by Saxena seem to be quite plausible, it may be noted that under the impact of modernization, the traditional taboos and restrictions are rapidly disappearing; as a result the fertility difference, if any, caused by these factors, are also likely to disappear in course of time.

Food Habit as Factor

According to Sanyal[35] there is a direct correlation between food and fertility in that comparative nutritional deficiency accelerates the capacity for multiplication of species. This is an interesting point of view which requires further investigation.

Level of Consumption as a Factor

By comparison of the fertility data for 43 nations pertaining to the decade of 1960's, Heer[36] has concluded that the fertility is directly associated with per capita net national product when controls for per capita newspaper circulation and for infant mortality are instituted. On the other hand controlling for net national product per capita and infant mortality, per capita newspaper circulation is inversely related to fertility, and, with controls for per capita net national product and newspaper circulation, fertility is directly associated with infant mortality. Chandrasekhar[37] has made a mention of the presence of a psychological drive associated with incredible poverty and low level of living which offer no pleasure in life save that of sexual intimacies.

Social Immobility as a Factor

According to Thompson[38], "In countries like India, where capillarity is small because of a rigid caste system, there is no tendency for birth rate to decline and for population to die out; just as a very solid substance (copper or iron) will prevent any considerable capillary movement in a

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[33]E. D. Driver, *op. cit.*

[34]G. B. Saxena, "Differential Fertility in Rural Hindu Community", *Eugenic Review*, Vol. 12, Sept. 1965.

[35]D. N. Sanyal, *Factors Affecting Fertility, Man in India*, Vol. 37, No. 4, Oct.-Dec., 1957.

[36]M. David Heer, *Economic Development and Fertility*, World Population Conference, Belgrade, 1965.

[37]S. Chandrasekhar, *India's Population*, Indian Institute for Population Studies, Annamalai.

[38]W. S. Thompson, *Population Problems*, McGraw Hill Book Co., 1942.

fluid, so a rigid social structure will prevent upward movement in a society and will thus obviate the danger of an individual development becoming so engrossing that the person has no time for rearing of a family." This seems to be a fundamentalist point of view holding the ethos of India's culture, by itself, to be responsible for the demographic pattern marked by high fertility. This requires a multidimensional probe; quick generalisation may be misleading.

Modernisation as a Factor

After surveying the research data relating to a number of developing countries, Concepcion[39] considers that in the short run at least, increasing modernisation may bring about increased fertility of certain sub-groups in the population. In addition, there are indications that major improvements in education do not necessarily bring about reduction in fertility.

Polygyny as a Factor

There are two points of view about the impact of polygyny. With reference to the prevalence of polygyny among the Muslims, Kirk[40] suggests that it increases the possibility for marriage and remarriage of women. By implication he considers this to be a factor promoting fertility. But among the Tamnes and other population of sub-Saharan Africa, Dorjahan found that polygyny tended to lower the overall fertility of the population. Lorimer, on the basis of his study among the Clanga population in Tanganayika, found no relation between polygamy and fertility. On the analysis of data collected in the 6th round of National Sample Survey, (July 1960) Pakrasi and Haldar[41] found that polygynous couples in general have significantly lower rate of live-birth, than that shown by the total couples surveyed in urban India.

Other Factors

Freedman[42] considers that fertility is likely to be higher among the employees of stable bureaucracies than among the employees of organizations subject to great uncertainty. Henry[43] has pointed out that amenorrhea, spontaneous abortion and infertility are associated with personality disorder, originating in socio-cultural stress.

Applicability of these interesting insights in the context of India requires to be tested with the support of systematic studies.

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[39]M. B. Concepcion, *op. cit.*

[40]Dudley Kirk, *Factors Affecting Moslem Mortality*, World Population Conference, Belgrade, 1965.

[41]K. Pakrasi and A. Halder, *Fertility of Polygynous Couples in India* (unp).

[42]Quoted.

[43]Henry, "Culture, Personality and Evolution", *American Anthropologist*, Vol. 61, No. 2, 1964.

Besides, with reference to the fertility situation in India, the significance of family planning programme requires to be examined.

Significance of the Family Planning Programme

During 1961-71, the decennial population growth rate in India has been 24.57 per cent. The birth rate during 1961-65 is estimated to be 41.0. On the other hand, the death rate has also rapidly declined though it is still high. The massive increase in the population as a result of almost stagnant birth rate and reduced death rate threatens the achievement of the national objective of ensuring economic and social welfare to the masses of the Indian people. It is this that imparts great significance to the family planning programme.

The development of the programme[44] began to emerge with the Second Five Year Plan with the four main components : (1) education to create the background of contraceptive acceptance; (2) service through rural and urban centres, including provision of sterilization facilities; (3) training of personnel; and (4) research. A large number of posters, pamphlets and folders, films, filmstrips, slides, and exhibits were produced. Public minded leaders in states and districts were appointed honorary family planning education leaders. Liberal grants were given to local bodies and voluntary organisations. Assistance was given to strengthen the staffs of a large number of health institutions and hospitals.

Later on, the scope of the programme was further extended. As already mentioned, during 1961-65, the birth rate was estimated to be 41.0. The immediate task of the family planning programme is to reduce this to 25 per 1,000 as quickly as possible. The general approaches to this goal include the following :

1. Popularizing the adoption of family planning methods including the intra-uterine device, voluntary sterilization, condoms, chemical contraceptives, coitus interruptus, abstinence, rhythm, and such new contraceptives as are found effective and acceptable in India for application.
2. Stimulating social changes affecting fertility, such as raising the age of marriage of women, increasing women's status, education and employment opportunities, old age security, education of children and elimination of child labour.
3. Accelerating basic economic changes so as to increase per capita income in real terms.

The family planning programme was reviewed in 1963 and reorganized.

The extended programme envisages three basic conditions necessary for fertility moderation; (1) each individual should know and feel that the

[44]B. L. Raina, *National Programmes in Family Planning*, India, (ed.), B. Berelson. Meenakshi Prakashan, Meerut, 1969.

immediate society or community to which he belongs has agreed as a group that having a small family size is the normal, desirable behaviour for its members; (2) each individual should have knowledge that a small family is valuable to him personally and should have knowledge of contraceptive methods; and (3) each individual should have contraceptive methods readily accessible.

It is thus found that crucial to the family planning programme is the knowledge about the programme itself as well as the attitude orientation of the different categories of the population to the programme.

Some information of the social dimensions of the awareness of, and attitude orientation towards the programme, as well as about adoption of the practices, is available from a report brought out by the Census Organisation.

As ancillary to 1961 Census, a socio-economic survey of about 500 villages was taken up by the Census Organisation in different parts of the country. The survey covered awareness of, attitude towards and response to family planning practices. The information has been consolidated and brought out in a single report 'Family Planning in Rural India'.[45]

A. Awareness of Family Planning Programme with reference to socio-economic variables at village community level

I. *Awareness with Reference to Distance from the Urban Centre*

At two extreme ends, namely 0-5 miles and 26 miles and above, the distance factor seems to have some association with the level of awareness. But, even at these two ends, it is not completely a neat pattern. The position is much more diffused in case of the villages which are neither too close, nor too far from an urban centre.

II. *Awareness with Reference to Level of Literacy of the Village Community*

At two extreme ends, there is correlation between the level of literacy and the level of awareness. Out of 17 villages with literacy of 10 per cent or less, in five villages, the level of awareness is nil, in 11 villages, it is 1–25 per cent and in only one village, it is 26–50 per cent. At the other end, out of the 12 villages with more than 50 per cent literacy, in nine villages, the level of awareness is more than 50 per cent, in one village it is 26–50 per cent, and in two villages it is 1–25 per cent. There is not a single village where the level of awareness is nil. If these two extreme ends are left out, it is difficult to find out any clearcut correlation between the level of literacy of the community and the level of awareness.

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[45]B. K. Roy Burman, *Family Planning in Rural India*, (ed.) Office of Registrar-General, India (mimeograph).

III. *Awareness with Reference to Size of Population*

Though it is difficult to say that in India, as whole, the level of awareness is always influenced by the size of the population in the villages, in several States, it seems that size of the population in the village, is also one of the features which is associated with the level of awareness of family planning programme.

IV. *Awareness with Reference to Dominant Religion of the Village*

It seems that the level of awareness is comparatively higher in the villages where Christianity is the dominant religion. It tends to remain low in the villages where Islam is the dominant religion. A more diversified picture is obtained in the villages where Hinduism is the dominant religion.

V. *Awareness with Reference to Dominant Caste Category*

It is found that the level of awareness is lowest in the villages where the scheduled castes constitute the majority of the population. It is somewhat higher in the villages where the scheduled tribes and other Hindus are dominant. It is highest in the villages dominated by other backward classes and other categories of population.

VI. *Awareness with Reference to the Success in the Implementation of the Land Reform Measures*

It appears that in the villages where land reform measures have been more successfully implemented, the extent of awareness of family planning programme is also more.

VII. *Awareness with Reference to Nature of Functioning of Cooperative Societies*

Though there is slight tendency of more awareness to be found in villages where cooperative societies are functioning successfully, it is difficult to say that any crystallized pattern prevails in this matter.

VIII. *Awareness with Reference to the Existence of Functioning Women's Association*

It is found that neither the existence nor the nature of functioning of women's association has any significant bearing on the extent of awareness of famiily planning programme in villages.

IX. *Extent of Awareness with Reference to Existence and Nature of Functioning of Youth Clubs*

It is found that neither existence or non-existence of youth clubs, nor the manner of functioning of the youth clubs, have much bearing on the extent of awareness of family planning programme in the villages.

B. VARIABLES AT THE INDIVIDUAL LEVEL ASSOCIATED WITH ATTITUDE TOWARDS FAMILY PLANNING PROGRAMME

I. *Attitude with Reference to Age of Child-Bearing Woman*

The study shows that till a woman attains the age of 20, there is little positive attitude towards F.P.P. After that, positive attitude towards F.P.P. goes up. But even then till attaining the age of 30, round about one-fifth of the females develop positive attitude towards F.P.P. and the rest have either negative or indifferent attitude towards F.P.P. After attaining the age of 30, about one-third of the females develop positive attitude towards F.P.P.

II. *Attitude with Reference to Age of Head of the Household*

It is found that except for the age-group 20 years or less, the higher the age-groups of the heads of the households, the larger is the proportion of those who have positive attitude towards F.P.P. In the age-group 20 years or less, slightly a larger proportion of persons than those in the age-group 21-30 years, have positive attitude towards F.P.P.

III. *Attitude with Reference to State and Duration of Marriage*

The study shows that while, among the recently married persons, there is more positive attitude towards F.P.P., there is progressively less positive attitude among the persons who are married for longer duration.

IV. *Attitude with Reference to Monthly Income*

From the particulars available, it is difficult to find any direct relation between the income level and the attitude towards F.P.P.; but the overall picture shows that the persons in the lower income groups are more positively inclined towards F.P.P.

C. ADOPTION WITH REFERENCE TO VARIABLES AT VILLAGE COMMUNITY LEVEL

I. *Adoption with Reference to Distance from Urban Centres*

The available data show that except for distances of more than 25 miles from urban centres, in other cases, the distance from urban centres does not affect the response to the programme to any significant extent.

II. *Adoption with Reference to Level of Literacy*

The available data do not show any consistent relation to the level of education and the adoption of the programme.

Another set of information about the success of the programme with reference to a number of socio-economic variables is available in an Evaluation Report,[46] of the Programme Evaluation Organisation (P.E.O.) of the

[46]PEO Report, *Family Planning Programme in India, op. cit.*

Planning Commission. Some of the salient findings are noted here:

(*i*) *Relation between knowledge, favourable attitude and adoption*—The evaluation study shows that knowledge and favourable attitude by themselves do not lead to action. There is a gap between awareness and practices of family planning method.

(*ii*) *Compensation*—The payment of compensation to the staff and promoters is found to be a useful adjunct to the programme but it has to be viewed as an *ad hoc* measure. Experience has shown that in spite of the high incentives offered, progress had been very uneven. The canvasser or the motivator system, though useful for the propagation of the programme, had been given undue importance neglecting extension education.

(*iii*) *Involvement of local leaders*—Not much progress has been made in the involvement of village leaders at the local level in supporting the programme.

(*iv*) *Accomplishment with reference to different methods*—The average accomplishment per family planning centre was generally more for the urban centres as compared to the rural centres for the period 1966-67 for all the methods; but this was not so, for the year 1967-68. While there was a fall in accomplishment in IUCD both in rural and urban areas, the rise in vasectomy was very considerable in rural centres as compared to the urban centres.

Considering the urban areas as a whole, both IUCD and vasectomy programmes received a set back in 1967-68 as compared to the previous year. In contrast to this, tubectomy had become relatively more important in 1967-68.

The urban population had responded more to IUCD than to vasectomy as compared to the rural population. Besides, unlike in urban areas, the programme of vasectomy had gained considerable momentum in rural areas in 1967-68 as compared to the previous years.

(*v*) *Response from the different cultural groups*—The rate of adoption of the three methods varied from 8.8 per cent of the Hindu households to 5.2 per cent of Muslim households. Response of the different occupation groups to the family planning methods varied somewhat. Vasectomy was most popular among labourers and IUCD and tubectomy among the cultivators.

(*vi*) *Communication*—The investigation showed that person to person communication and discussions relating to family planning were more carried out by local leaders than by the general respondents. Three-fourths of the local leaders reported to have talked to others regarding family planning methods; whereas the corresponding figure for the general respondents was only 39 per cent.

(*vii*) *Additional children desired*—One of the programme goals is to promote the small family norm. About one-half of the respondents desired to have more children. The proportion of respondents desiring additional

children declined at higher orders of living children, more so if there were at least two sons.

(*viii*) *Attitude towards sterilization*—Majority of the respondents favoured operation if the couples did not want any more children. Generally vasectomy was favoured. As to the time of sterilisation, over two-fifths favoured it after the fourth child.

(*ix*) *Motivation for adoption*—Two factors that seem to affect the pattern of response to the family planning programme are : (1) people's concern about infant mortality, and (2) their dependency on sons during old age. There is also a preference for sons due to religious reasons.

(*x*) *Age-group and adoption differential*—A large bulk of both the tubectomy and the IUCD sample belonged to the age-group 20-40 years, whereas it was 30-50 years in the case of vasectomy sample. Again, while in the case of vasectomy, there were more elderly people in the urban areas, than in the rural areas, it was the other way round in case of tubectomy and IUCD sample.

(*xi*) *Duration of married life and adoption differential*—The average period of married life for adopters was about 18 years and varied from 19 years in case of couples adopting vasectomy to 16 years for those adopting tubectomy and IUCD. Here also significant differences were observed between rural and urban areas. The average number of pregnancy per adopting couples varied between 5 and 6 in all the three cases. The difference between the rural and urban areas was more marked in respect of couples adopting tubectomy and IUCD than those adopting vasectomy.

(*xii*) *Educational level of husbands and adoption differential*—In general, the educational level of husbands of those who adopted tubectomy was higher as compared to others. The response of the different occupational groups varied significantly as between the three methods of family planning.

(*xiii*) *Occupation and adoption differential*—The response of the different occupational groups varied significantly as between the three methods of family planning. The cultivators' group mainly drawn from the rural areas responded more or less equally to vasectomy and IUCD programmes, whereas more labourers had adopted vasectomy as compared to the other two methods. In the case of those in service in cities, the response was highest to the vasectomy programme.

(*xiv*) *Exposure to communication and adoption*—It is highly interesting to note that substantial proportion of adopters or their husbands both in general and urban areas had little or no exposure to communication and innovation, such as education, use of improved seeds and fertilisers for cultivators, use of electricity, reading of newspapers and periodicals, etc. It is also interesting to observe that a large proportion of adopters had not practised any other method of family planning before.

(*xv*) *Reasons for non-adoption*—Most important reason given by the general respondents for not adopting family planning method was the

desire to have more children and was mentioned by 48 per cent of the general respondents and 40 per cent of the local leaders. Lack of knowledge of methods or lack of faith in family planning were mentioned by a substantial proportion of general respondents. Another reason prominently mentioned related to apprehensions about the after-effects.

The report has summed up that with dedicated and dynamic leadership at all levels, improvement in service, efficient functioning of staff, effective supervision of, and guidance to grass root workers, better preparation of the couples and prompt attention in case of complaints, greater involvement of non-officials, addition of new channels of service, concurrent appraisal to find out expeditiously efficiency of the various methods and approaches and better feed-back arrangements, it should be possible to achieve a break-through in stabilizing population growth.

While it is always desirable to sustain an optimistic attitude, when a programme of vital national interest is launched, it is also necessary to give some consideration to evolve a long-term strategy for the success of the programme. As noted earlier, the programme involves a trans-evaluation of values; it is, therefore, necessary to derive the strategy from the cultural processes of India. Eisenstadt[47] has drawn attention to the fact that in India the cultural and political orders have remained more or less dissociated. This analysis is of great importance for the matter under consideration. If the long-term trend of virtual dissociation of cultural processes from the centres of political power are kept in view, it would be obvious that the elite role for promoting family planning as a way of life cannot be effectively played by the political leaders, in their capacity as political leaders or by the administrative bureaucracy, deriving sanction from the power structure of the society. The elite must come out of the other sectors of the community; may be from the universities, ideologically oriented youths and so on. The motive force for the operation should not be power, but prestige transcending power. But it is to be appreciated that an effective elite cannot be created artificially. It emerges in a congenial social climate. But, at the same time, in the modern age of "self-directed humanity", stimulus for emergence of new elite can certainly be provided by complete analysis of the relevant social process. This is a task which legitimately pertains to the social scientists. But the social scientists can discharge their responsibility satisfactorily not as detached viewers, but as participant analysts, that is, by making a synthesis of humanistic tradition and scientistic tradition of social science.

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[47]S. N. Eisenstadt, "Transformation in Modernization in India", *American Social Review*, Oct, 1965.

SUMMARY OF THE PROCEEDINGS OF THE FIRST SEMINAR

V. JAGANNADHAM*

The first seminar on Family Planning Policy and Administration was inaugurated by Prof. D. P. Chattopadhyaya, Minister of State in the Ministry of Health and Family Planning. In order to speed up the implementation of the programme, he wanted the participants of this series of seminars to tell the Government as to what they thought "ought to be done in the field of family planning and population control". He said that "a very wide awareness and an atmosphere of social acceptability has been created. Is it possible that we need new approaches both in the field of motivation and services, if we have to bridge the gap between the wide awareness and the relatively low level of acceptance?.... "Perhaps the gap between awareness and acceptance is bound to be there in any programme that seeks behavioural change. Especially in a traditional society like that of India, such a programme takes time to find roots. The gap between awareness and acceptance and practice is, therefore, bound to take longer to fill in our country than in other societies."

The Minister also made a forceful plea for modernisation in all directions which could lead to the acceptance of the small family norm. "India's economic situation being what it is, we cannot wait for the process of modernisation to be completed in all directions before the idea of a small family can be spread. The small family norm has to be presented as part of the total development package in political, social, and economic terms. I hope, therefore, that this seminar would help determine the manner and the method by which this can be achieved."

Presentation of Papers

After the welcome address of the Director and the inaugural address by the Hon'ble Minister, the various papers submitted for the seminar were introduced.

After the presentation of the papers, Shri K. K. Das, Secretary, Ministry of Health and Family Planning, said that though the family planning programme had made good progress, it seems that it had reached a plateau and more probably a declining plateau, and that we are looking to this series of seminars so that academicians, administrators and others interested in

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the programme could suggest a solution to the problem. He suggested that, apart from a critical examination of the existing policies, it would be a good thing to concentrate upon offering concrete suggestions for changes in policy and administration to make the programme more effective. He also emphasised the need for a look at the technological aspects.

The discussion was then thrown open, and the main points are summarised below :

1. *Problem of Numbers*

The seminar brought to the surface very sharply the inter-relationships between the growth in human numbers on the one side and the growth in goods and services on the other. The participants, by and large, pointed out that there had been an underlying assumption that the growth of population has to be considered in relation to material resources. This relationship has become all the more critical as the norms pertaining to standards of living had been moving upward and that the growth in numbers affects these norms adversely. This critical relationship seems to persist notwithstanding the possibilities thrown open by developments in science and technology in regard to production of goods which could meet the needs arising out of a fast rate of human reproduction.

At a very early stage in this seminar, some questions were raised about the new respectability of Malthusianism. This theory appears to have been propounded afresh by the modern developing States and is pursued by intellectuals without a critical examination of the implications of the indirect invasion of the privacy of marital and family affairs. A fear was expressed "whether motivation exercises do not ultimately result in manipulation of private attitudes for the gain of some parties in power." Another opinion expressed was whether the population control and the family planning "movement" or "drive" was not an alibi for the inability of the Government to bring about the desired rate of growth in development. In fact, this section of opinion felt that the family planning "drive" was intended to cover the deficiencies or failures of the Government's development plans, as if rising population alone was preventing a rise in the standard of living. It was said that the country has the resources and capacity to bear the burden of increasing mouths because each mouth is accompanied by two hands and a brain. If the Government were to provide education, health, nutrition, recreation and employment for the growing labour force, the population problem does not exist and it was basically a question of scientific resource mobilisation and utilisation. The population growth rate in India was by no means higher than in many parts of the world and the density of population in India was still lower than in many developed countries. There was, therefore, no room for the extraordinary concern and/or anxiety about the growth of population, so as to impel government to undertake a relentless drive to check the birth-rate. Some participants suspected that behind the Governments'

concern and anxiety about the growth of numbers and its commitment to family planning was the heavy impact of foreign advice and financial aid, though no one stated what the reason for this could be. Some participants questioned, in the context of State-citizen relationships, the theories of the State insisting upon imposing irreversible methods of population control such as vasectomy and tubectomy. A feeling of anxiety was expressed particularly from the standpoint of the inarticulate millions in India whether the bureaucracy was justified in imposing penalties by bureaucratic sanctions such as withholding of hospital, education or housing facilities for the couples who produce more than three children. The offer of monetary incentives for the technicians and professionals for conducting, and to the consumers for undergoing, irreversible processes of control of reproduction was also seriously questioned. Many participants felt that such an approach was the direct result of a target-oriented programme.

On the other hand, several participants supported the present family planning policy though some of them had reservations about the administrative measures. They urged that, notwithstanding increased and increasing agricultural production and industrial development, the rise of population in absolute numbers was bound to outpace economic development. It was essential, therefore, in their opinion to pursue vigorously the family planning programmes in their purely physical form. They supported the nature of the clinical programme though they felt that other measures in the shape of education in population policy, and positive incentives to encourage people to have smaller families were necessary in the long term.

2. *Policy Implications*

The reference to these views ranging from respectability to Malthusianism, from rejection of state incentives to more purposeful implementation of the present programmes engaged the participants in a discussion of the policy issues, because in one form or another, the range of differences indicated above, forms part of the mosaic of attitudes towards the family planning problems in the country. There is no, and probably there cannot be, unanimity about any public issue, much less, about a matter which affects largely a private affair concerning marriage, sex and reproduction. However, the differing attitudes, expressed and reflected in the seminar, give an indication, in a microscopic way, of the wide range of views at the macro level in the country as a whole. A function of policy-making and policy-makers is to secure a certain degree of harmony between private affairs and public needs or interest through dialogue, debate and consultation. In the present family planning programme which is largely conceived and operated by the administration, it is felt that, while many elements of policy are present, the chief one, namely public debate before decision, is missing. A feeling was expressed that the support of the highly placed persons in Government to the programme without acquainting themselves with public

reaction and acceptability, without informing themselves of the psychological social and cultural aspects of the matter, could not be treated as policy. In the opinion of some participants,these messages and statements form part of public debate and also constitute policy. There was, however, a sharp reaction against this facile view of policy. That these by themselves do not constitute policy is immediately understood but what constitutes policy is yet not clearly understood. By way of an illustration, it was pointed out that a statement of the concerned minister in a convocation address could not be regarded as a statement of policy. Yet, some participants pointed out that there existed a policy statement on population on the part of government and it could be accepted as such to offer guidance. Others assumed that what constituted policy was the stamp of approval of the legislature—central and state. The deliberative wings of the local authorities and national and statewide voluntary or non-Governmental organisations also could debate and formulate policy.

As against this view of debate and decision about policy, a view was expressed that "to have no policy is a policy". This view arises out of the fear that to submit a policy for discussion, debate and dialogue is to raise the hornet's nest of controversy, conflict of opinions and consequent confusion; whereas the situation called for courageous and consistent action by way of a "drive". It was felt by them that an administrative programme could best serve the needs of the situation. Administrative schemes provide the base for flexibility, adaptation and adjustments to suit the exigencies of the desperate situation.

The participants of the seminar were, by and large, in favour of wider public debate and approval through legislatures, etc., of the whole range of population policy. It was felt and hoped that such public debate would tend to convert government policy into a national policy or a policy that the community would feel as its own.

The lack of clear approval of the community was identified as an element missing in the contemporary family planning programme. The presence of other elements such as the statement of long and short range objectives such as reducing the birth rate from 41 to 25 per thousand, or the guidelines for action such as the directions for I.U.C.D. or sterilisation drives or the heavy financial allocations under the Fourth Five Year Plan and the organisation—personnel mechanism developed under the programme—it was felt by some, did provide the policy frame for the administrative scheme of family planning.

What then are the special advantages of a policy base for the programme is a pertinent question which the seminar participants were anxious to understand. The following were mentioned as advantages of a policy base for the administrative programme :

1. The communication of a sense of national top-level priority for the programme. Since 1948, the Government of India have been formulating policy resolutions in areas which were identified as matters of top-level

national priority. By way of illustration, mention could be made of Industrial, Scientific, Education policy resolutions and statements. Recently, the Central Minister for Social Welfare proposed to introduce a child welfare policy resolution in the current parliament session. It would be in the fitness of things to enunciate a family planning policy through a policy resolution duly adopted by Parliament. The same could also be submitted with appropriate modifications to the State Legislatures and local authorities. This would ensure the commitment of the community to the policy and thereby ensure participation in the implementation.

2. The formulation of a policy resolution at central and state levels would secure the needed consistency between family planning and other socio-economic policies of the Government. For example, the family planning policy has to be reconciled with the strength of voters in a democracy; since the union-state financial relationship is based upon "per—capita" grants, the State Government fears reduced political influence, if they pursue a reduction of births programme. In the absence of a coherent and comprehensive policy statement, these contradictions between fiscal on the one hand and social policies on the other do not seem to lend themselves to reconciliation or resolution. As a concrete recommendation to the Government, the seminar participants felt that a comprehensive policy resolution on population was the next step to be adopted: this would be a positive contribution and imply acceptance of a policy of social welfare rather than a negative programme of birth-control.

3. There was a demand that, instead of relating the numbers issue to the broader national aggregate of population, it would be more desirable to have a family welfare orientation so that the policy becomes meaningful to individuals living in families. The latter, it was felt, would be permeation of community understanding of the nature of the problem and facilitate realistic appreciation of the objectives of limiting numbers. In this context, it was pointed out by some that the limitation of numbers to two or three children in the interest of the health and happiness of the family fulfils this prescription. On the other hand, there was the view that happiness is a metaphysical concept and, instead of it, the objective for a family should be related to an economic standard of living. A more direct question was asked as to whether the limitation of family *vis-a-vis* national goals is to be in terms of food or industrial development or cloth production or housing. Furthermore, the limitation of numbers seemed to suggest a negative approach whereas postponed procreation and spacing births was more positive. The latter would have more relevance to happiness as well as to economic well-being.

All the suggestions about limitation of number of children or postponement or spacing procreation assumed that the mass of individual couples in rural areas considered numerous progeny, as a burden. That view did not appear to prevail among the less educated. It was pointed out that if

the government could provide education on a functional and imaginative basis and gainful employment to the bulk of the people, there would perhaps be no need of any special external drive to control births or fecundity.

Family planning was an alibi to what one speaker called "bankruptcy of Government in development planning". In contrast to this view, family planning was projected as a way of life towards modernisation. by other speakers. These two views frequently dotted the debates in the seminar. The former view was the product of dissatisfaction with the overall economic growth rate. On the other hand, there were those who held the latter view that there was no automatic diminution in family size consequent upon economic growth unless family planning becomes a way of life and a habit with couples. The advocates of the latter view held that, without reference to the rate of growth of economic development, the nation should have a family planning movement and family welfare policy as a way of life to help accelerate modernization. Comprehensive social welfare measures would enable the families to gain confidence and adopt small family norms.

Administrative Issues

The family planning programme as it exists in the country today is an administrative scheme with a top heavy pyramidal structure and there was a feeling among the participants that the position needed radical modification. It was felt that the administrative programme of family planning be modified in such a way as to relate it to a larger and more positive ideology of family welfare. If the programme was so related to a larger ideology, the need for co-ordination of sub-policies and activities of several departments assumes greater significance than mere administratration of a programme with a narrow scope by a single department either at the Centre or in the States. The system of administration thus flows from the policy that emerges after debate and decisions in the legislature.

Two principles which were, by and large, agreed upon were that research and administration should be decentralised.

Much research is taking place but there does not seem to be as much investment upon research as would enable immediate application for identifying and meeting indigenous needs. There was much need for investment upon bio-medical and demographic research as upon administrative research. Instead of *ad hoc* investments upon sporadic schemes, investment upon and organisation for research also needed to be planned on a long term and systematic basis.

On administrative organisation, personnel and procedures, the emphasis in the Seminar was upon decentralization, delegation and flexibility as well as freedom and initiative for technical personnel in decision-making at the field level. In this context, the seminar discussed the apparent lack of commitment on the part of several states and local authorities. The lack of commitment was attributed to the fact of the family planning scheme being

a wholly centrally sponsored and financed scheme. It had been claimed that "Central Government is the leader, guide, catalyst and underwriter" of the family planning scheme. Consequently, the states and local authoritis saw no need to take any initiative and the procedures were rather rigid—something imposed from above. In order to overcome these rigidities and difficulties, the seminar suggested that the district should be recognised as the base of operations and that a revolving fund, detached from the annual budget allocations and accounting procedures should be constituted.

The top heavy organisation with many councils and committees at the apex of the pyramid in the Central Government is proving dysfunctional in so far as these bodies meet infrequently, and decisions are delayed. Further, this tended to weaken the base at the operational or the district level.

At the district level, the organisation did not have a built-in mechanism for working as a team. The powerful personality of a district officer may at times succeed in securing good team work and consequently good result but the organisation at the district level was not able to operate as a team because of its inherent weaknesses. This aspect of reorganisation of the administrative system at the district level needed immediate attention on the part of the state and central governments.

Discussions in the seminar also centred upon shifting the location of the family planning department from the present Ministry of Health and Family Planning to Education and Social Welfare. Suggestions ranged from the creation of a separate Ministry of Family Planning and Social Security to the abolition of the present family planning department and making it a part of the activities of all development ministries and departments. No unanimity of opinion prevailed about the location of the special organisation for family planning.

Discussion shifted from the locale of the organisation to the bureaucratic management of the scheme. It was felt that, irrespective of wherever the scheme was located, there would be no improvement in management, unless the present bureaucratic system of management was modified by associating more openly and actively the elected and non-official leaders and voluntary organisations with the management of the scheme.

Does Diffusion Model or Intensive Agricultural Development Model work in Family Planning ?

The seminar also discussed what strategy would achieve greater success under the family planning programme. Would concentration in select areas and its demonstration effect have greater pay-off than the present method of diffused application of scarce resources all over the country? Some participants were of the view that concentration in urban areas would create greater impact and they *pointed* to the difficulties of reaching the widespread rural areas wherein the traditional modes and values

tended to offer greater resistance to the adoption of the birth limitation methods. The conditions of living in rural areas also did not enable many people to practise the methods that they are made aware of. However, differences of opinion prevailed about the responses of rural—urban population and also on concentration—diffusion issues.

On one point, however, there was greater agreement, namely, that the analogy of intensive agricultural development strategy and tactics does not hold good in the realm of human reproduction because of the complex variables in human motivation and behaviour. The family planning programme administration should discover strategy and techniques appropriate for itself among the geographical and cultural groups that it addresses itself to.

On another point, namely, the need for selection of strategic groups particularly in the organised sectors of economy and society there was considerable consensus. Women, wherever they are, are the single largest group identified as suitable and necessary for special communication and mobilisation because they are the mothers as well as carriers of change. Women in organized industries and government employment constitute an easily accessible group for spreading knowledge, acceptance and practice of the programme. This was reinforced by the peculiar phenomenon in plantations where there was great demand for women labour and as such there was no predilection in favour of sons and prejudice against daughters among the plantation workers. This, it was felt, would provide a clue to the acceleration of the programmes for gainful employment among women and mass literacy for women folk. However, doubts were expressed whether a male dominated economy and bureaucracy could achieve such acceleration especially when man is still regarded as the chief bread winner and dependence of man upon a woman bread winner is shied from. In this context, the current scarcity of employment opportunities even for men made it very difficult for the family planning personnel to plead for greater employment opportunities for women.

There was considerable dissatisfaction in the use of penal measures by the administrators under administrative directives. By way of illustration, it was mentioned that some states have passed administrative orders to withhold maternity benefits, education concessions, housing facilities to employees who have more than three children. It was said that this penal approach was anti-social in its impact because the children suffer more than the so-called delinquent or erring parents. Such administrative orders were considered to be an abuse of discretionary powers under a scheme which had no statutory base or framework and there was no possibility of protection of the "rights" of the beneficiaries *i.e.*, the citizens consuming the services under the administrative scheme.

Reference was also made to the need for adopting "consumer satisfaction" as the focus in the management of the scheme. Investment

upon promising consumer satisfaction in human welfare schemes has greater pay off because such satisfaction may provide a multiplier effect upon the otherwise reluctant and indifferent mass of illiterate and unemployed or under-employed population. The multiplier effect corresponds in social welfare fields to demonstration effect in the material growth fields. Emphasis was placed upon the effectiveness of persuasive educative measures as against penal measures in securing the willing participation of the people in the implementation of the programme.

It was also felt that the present methods of recruitment, staffing and deployment of the personnel in the family planning organisation did not seem to ensure much effectiveness in the above direction. Particular attention was drawn to the mal-distribution of medical and para-medical personnel as between rural and urban areas. The poor training and motivation of personnel particularly of the ayas, midwives and auxiliary nurses was specifically pointed out. The low prestige attached in the community and government service to the postings in the family planning department, particularly of qualified doctors, was found to be very discouraging in attracting persons of suitable calibre and temperament to work in the family planning organisation. The piece wage system of rewarding the doctors for vasectomy or tubectomy was also believed to be dysfunctional as it is resented by some medical professionals.

The decision-making processes for adopting and for shifting the emphasis on different methods of family planning methods needed detailed study. It appeared to some participants in the seminar that the family planning drive and its emphasis on different methods at different periods starting with IUCD, proceeding to sterilization and concentration on condoms reflected a lack of systematic measurement of the problem or anticipation of needs. It seemed to reflect more the passing whims of a political leader or expert under pressure from outside. To add to these, there was no systematic follow-up of the demands and responses of beneficiaries. For example, the IUCD drive was a classic example of great faith brought to nothing because of a lack of proper follow-up. Probably it would have yielded good results if the medical personnel who did the insertions cared to examine the complaints of the beneficiaries and removed the fears and doubts about the after-effects. About the irreversible methods of vasectomy or tubectomy, there was a feeling that the lack of proper follow-up would lead the 'drive' towards neurotic fears about them. There was satisfaction about the increasing numbers of condoms sold or distributed under a subsidised scheme but there was no means of knowing about their effective utilisation.

This phenomenon of non-accountability for failures and wastages in Government departments, according to some participants, appeared staggering when put in juxtaposition with the great concern for accountability for non-rendering of accounts in time among voluntary organisations.

The phenomenon of double standards in accountability as between Government departments and voluntary organisations was a source of tension and dissatisfaction.

Two administrative factors were mentioned in this context as responsible for a lack of proper follow-up. (1) There was not an adequate number of medical and para-medical personnel for the follow-up programme: (2) the personnel in the department have neither permanency of tenure nor promotion prospects as the family planning programme is purely temporary. It was suggested that these aspects could be remedied by administrative action by having a proper "personnel" policy to administer the family planning programme.

It was brought to the notice of the seminar that the technical personnel in the programme seldom contact the lay leaders of public opinion or voluntary social workers within the area when they visit villages. The technical personnel seem to be concerned about their specialised job rather than the "human" and national significance of the programme. Such indifference is attributed to poor "commitment" or "morale" on the part of the personnel. Remedying such deficiencies as these needed the attention of the state and central leaders.

It was also brought to the notice of the seminar that consequent upon heavy concentration upon incentives for vasectomy and tubectomy operation methods, the normal public health programmes were being neglected. As a result of this neglect of health services like malaria and small pox eradication, epidemic diseases were again raising their heads in areas where these were assumed to have been eradicated.

Experience in community development administration, especially in its early stages seemed to lend credibility to this view. During the heyday of community development, less prestige was given to the normal government functions such as collection of land revenue and maintenance of law and order. Indifference to these essential functions of Government had an adverse effect upon government's functioning. The lost image of government could not be restored subsequently.

These views were questioned by some. For example, it was said that by shifting the locale of the Department, or making the personnel permanent. not much improvement could be achieved because the malady was much deeper. A proper climate for family planning programme did not exist. Political will was hampered by differences of opinion among the political leaders and parties. Skills and equipment were wanting because of shift in methods. Motivation was lacking because of the feeling that family planning was being advanced as an alibi for failures in the sphere of material development. The negative approach under family planning—namely, the limitation of numbers, does not appeal to people who consider their children, particularly the sons, as wage earners, as supporters in old age and as redeemers from some other worldly evils. In these

circumstances, there was a minimum or no correlation between private family needs and national needs. The methods adopted for communicating the family planning programmes in terms of national aggregate population control is not having the desired impact. A time has come to evolve a policy wherein family welfare orientation would form the basis of communication with the millions of families and newly married couples. This method of communication needs, in addition to the present use of mass media, a method of communication with individual families, particularly through the women members of the family, through population education or family life education among high school and college students and through adult education methods among the bulk of the illiterate adult parents.

In this respect, the dysfunctional aspect of a uniform pattern of staffing at the field level by two female and two male extension educators was pointed out. It was said that there was need for more women extension workers because it was through them that the motivation and orientation for family welfare could be achieved. A further point for consideration was the age, calibre and competence of extension workers. Most of them were young, urban-bred, sophisticated, English-educated women. The grown-up married women whom these workers go to educate about family planning question them about their experience in family life and family planning. Such questions destroy the possibility of establishing rapport between the extension worker and the client and consequently undermine the morale of the former and the faith of the latter.

Many factors like these elicited the comment that our "inputs in family planning are increasing but there is no proportional benefit by way of output". Comments like these call for a deeper critical analysis of the effectiveness of communication media and messages, of the personnel policies and staffing pattern, of the feedback of information and experience at the ground level. A field worker reacted sharply by saying that "many at the top level believe that there is policy, but at the bottom, we do not see any policy'. Many expressed the view that there was hardly any coordination at the field level and at the family level between health, education, welfare and family planning programmes. Also, many families have multiple motivations for adopting or rejecting small family norms. Individual family welfare as the bed-rock of the programme and a coordinated flow of services ensuring longevity for the children born at desired intervals, employment for all and social welfare/security services for ensuring minimum satisfaction at all stages of life alone would ensure success for family planning programmes.

A fulfilment of all these also did not seem fully to create confidence in family planning and small family norms among people whose values about private property, family security and national identity were still rooted in the joint family traditions of an agrarian society. For example, the tradition of social service or social work that prevails in a western

democratic society under the reformed christian ethic is something alien to Indian society. The concept of individual dignity, responsibility of local authorities for the indigent in their jurisdiction, the poor law and means test approach and the reaction of voluntary organisations to the care of the poor either through private philanthropy or mutual aid scheme or of commercial service organisations is very negligible in our society and country. In these circumstances, people still rely, by and large, upon appeal to joint family or other kin, caste and regional group loyalties for discharge of socio-economic obligations. Therefore, state programmes of individual/family welfare operated through formalistic bureaucracies, are suspect and these fail to impress the bulk of the people about their genuineness or accessibility according to individual/family needs or circumstances.

The deep-rooted family dependence-proneness of the people in India coupled with lack of faith in the bureaucracy makes it difficult for the Government to operate successfully the family planning programme without the active involvement, commitment and missionary spirit of sound, respectable non-governmental organisations either on an agency—commission basis or on an autonomous competitive basis. But the traditionalist bureaucracies bring to bear an attitude of scepticism and distrust towards non-governmental organisations and consequently, place all sorts of hurdles in their effective functioning. Each is jealous of the other's privileges and prerogatives : consequently, very little feeling of community of interest prevails between the state and society or citizens and government. The non-governmental organisations receiving grants from Government are described as "sacred cows" which are pampered more by sentiment than by sound reasoning of their usefulness. The Western attitude towards the beneficial role of non-governmental organisations or for that matter, of local governments, is absent in our society. Western attitudes and experience had no relevance, according to some, in our socio-political situation. There was a suggestion that the involvement of voluntary organisations and local authorities must not be based upon an indiscriminate faith in their role as a universal proposition but must be based upon a cool calculated assessment of the competence and character of these bodies.

SECOND SEMINAR

JUNE 17—19, 1971

INAUGURAL ADDRESS

PROF. A. K. KISKU*

Mr. Chairman, Ladies and Gentlemen,

I am very glad to associate myself with the series of Seminars which this august Institute is organising on family planning. I am quite sure that the association of intellectuals with this very important programme will be beneficial and will help the programme planners in shaping their policies.

The population problem which we are facing today is a direct result of our comparative success in reducing the death rate. In recent times, the death rate has been steeply falling. With further improvements of rural sanitation, provision of more fresh drinking water, and introduction of immunisation and new nutrition programmes, we can look forward to a further reduction in the death rate. Our growth rate will, therefore, continue to be high, unless the family planning programmes are a success.

In a programme like that of family planning, which is a part of the overall economic and social change to be brought about in the country, there will be impediments. What has been achieved in West over the last 100 years or so, with the advantage of high economic development, is sought to be achieved in India in a matter of two decades and the means are persuasion and education and the use of media of mass communication and extension education. As the other coordinates of adoption of family planning, such as education and higher standard of living, are not yet fully developed in India, the challenge is much greater, calling for a matching response and effort from all those who are engaged in the promotion of family planning.

The time has now come when we must think in terms of making family planning programme a key to our population problem. Whereas only 28 per cent of the population of the developed countries is under 15 years of age, 42 per cent of the population of the developing countries is under 15 years of age and the overall dependency ratio is very high in these countries. It will be seen, therefore, that without a rapid decline in birth rate, our economic development will be seriously affected by this demographic imbalance.

A rapid increase in population is also bound to create tensions in

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social as well as family life, especially as the emergence of a new economic organisation brings about changes in the family structure. It is also recognised that the per capita benefit of national economic development is seriously diluted by a high rate of growth of population. Realising all this, the Government of India have made the family planning programme a part of the overall national development plans.

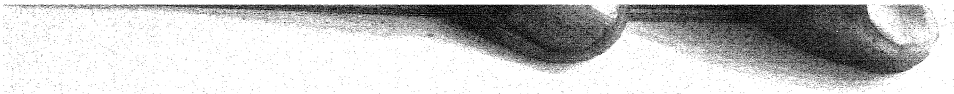
In a learned assembly like this, I need not dilate upon the details of the progress of this programme and its ups and downs. But one thing stands out, and that is that all studies indicate that there is a high degree of awareness of family planning. In spite of differences in different studies, it is recognised that there is a favourable attitude towards family planning. Against this almost universal acceptance and a widely-prevalent favourable attitude, the actual practice of family planning is rather low. Our programme planners must, therefore, address themselves to this task and, if necessary, reshape their approaches and techniques to make a deeper impact so as to increase the actual practice of family planning. I am sure that your deliberations in this seminar will help in placing things in their correct perspective and in throwing up fresh ideas on the subject.

I wholeheartedly welcome the initiative taken by the Indian Institute of Public Administration in trying to collect together leading intellectuals of this country to discuss this subject. A regular and effective channel of communication between the intellectual elite and programme planners and administrators is essential for the success of any development plan, even more so in the field of family planning which seeks to create fundamental behavioural changes in society. We look forward, therefore, to the results of your deliberations which would be most valuable to us.

PAPERS PRESENTED

AT THE

SECOND SEMINAR



ADMINISTRATION OF FAMILY PLANNING PROGRAMME IN UTTAR PRADESH

S. D. PANDE*

I am grateful to the Institute of Public Administration for allowing me an opportunity of presenting some of my views on the administration of the Family Planning programmes in U.P. I may state—candidly—at the outset, that the views presented are not based on any sophisticated analysis of the aggregate data, or depth-studies or a study of the work-style, linkage mechanisms or such other tools or statistical analysis. The views presented are those of an administrator in charge of a vast and complex programme who has observed the various aspects of the State-district relations, the role of the P.H.C. doctors, the role of change-agents and client-interactions. These are, thus, the views of a 'participant observer' who has watched the programme closely at the various levels—village, town, block, district, divisional and at the State level. A study of the performance of the programme in U.P. brings forth most clearly the challenges and the bottlenecks involved in the fulfilment of a programme of such huge dimensions. The processes of social and economic changes which have led to an autonomous adjustment in fertility-behaviour among families in other countries or even in the other States in India have had imperceptible impact in U.P.—the most populous State spread over 1,12,000 villages and 267 towns and cities. Why this has been so is an interesting subject of research. My competence to speak in the seminar arises mainly because of my association with a task of such magnitude.

I have divided the paper into three parts. The first part gives a small introductory background of the administrative set-up. The second part deals with the progress of the programmes from 1965-66 and the first two years of the Fourth Five Year Plan. In the third part, I would like to share a few thoughts—stray indeed—that have occurred to me in regard to the administration of the programme, the need for redirection and reorientation to make it more purposeful and effective. My thesis for your consideration may be very simply stated. The intricate problem of the administration necessary in this field has been and continues to be neglected, to the detriment of Family Planning programme in general. I am, therefore,

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of the view that serious and sustained efforts should be made to develop a working concept of the administration in specific aspects which may be applied for the betterment of the programme. It may be argued that the deficiencies in administration of the massive Family Planning programme are due to the newness of the programme and a lack of experience, but have we really learnt to modify the administrative aspects on the basis of the experience that we gain, year after year, and, if so, how serious have been our efforts to rectify and modify? We all talk of the importance of evaluation at every stage and also of feed-back. Have we really evaluated all aspects of the programme and really tried to feed-back the findings? I would leave you to answer these questions at the end. I may add that my concept of administration of Family Planning is, more or less, the same that has been propounded by various authorities, *viz.*, that of planning, organization, direction, staffing, coordination, reporting, budgeting and evaluation.

I

U. P. at a Glance

The State of Uttar Pradesh, a centrally situated State of Northern India is roughly about 800 kilometers long and 280 kilometers wide. It stretches over an area of 2,94,366 square kilometers. It has 11 revenue divisions, 54 districts, 231 tehsils, 267 towns and cities, 678 community development blocks, 875 primary health centres, 7000 sub-centres and 1,12,000 villages

According to 1971 census, the State has a population of 8.83 crores, comprising 4.69 crores males and 4.14 crores females and it continues to be the most populous State of the country. The density has also increased from 250 persons in 1961 to 300 persons per square kilometer in 1971. The density is highest in the east and falls as one moves to the west and north.

Compared to the two earlier decades of 1901-1911 and 1911-1921, the population of the State has been increasing at a fast rate. The rate of growth was 16.66 per cent during 1951-1961; it has now increased to 19.73 per cent in 1961-1971.

The rural area consists of 98.8 per cent of the total area of the State and has 1.12 lakh villages. The urban population is 12.9 per cent of the total population which lives in 267 towns and cities.

In 1971, for every 1000 males, the number of females is 883 as against 909 in 1961. Thus, the number of females per 1000 males has gone down by by 26.

Although literacy has shown an upward trend by 3.9 points according to 1971 census as compared to 1961, it is still only 21.64 per cent. The

present literacy amongst males is 31.74 per cent and amongst females 19.20 per cent, showing an increase of 4.44 points in males and 3.18 in females over the 1961 census.

The average size of household has been estimated as 5.04—5.07 persons in a rural family as against only 4.87 persons in an urban household.

Marriage is universal, specially amongst the females. Child marriages are not uncommon. The average age at marriage for male and female has been 18+ and 15+ respectively. About 187 females per 1000 population are married.

About 40 per cent of the total population in 1961 was under 15 years of age and 5 per cent were 60 or above.

Hindus have a predominance being 63.76 per cent of the total population, followed by schedule castes (20.87 per cent), Muslims (14.62 per cent) and others (0.75 per cent).

According to the estimates of Registrar-General made in 1969-70, the birth rate is approximately 45 per 1000. The sample registration figures put death rate at approximately 23 per 1000. These figures have, however, yet to be verified.

Administrative Organisation for Family Planning Programme in Uttar Pradesh

The Family Planning Programme in U.P. is planned on the pattern laid down by the Government of India with the objective of creating a small size family norm through extension education methodology and by providing free service and supplies. The organizational and staffing pattern sanctioned for a big State like U.P. has to conform to the All-India pattern laid down by the Government of India with surprisingly little room for innovations and no consideration of various factors which influence the acceptance of the programme.

At the *State level* there is the Minister of Health of the Cabinet rank, assisted by the Minister of State, Health and Family Planning Programme.

At the Secretariat level, the Commissioner-cum-Secretary, Medical, Health and Family Planning is assisted by a Joint Secretary responsible for family planning only and heads the family planning cell in the Secretariat.

The various committees on the pattern suggested by the Government of India, namely, the Cabinet Sub-Committee, the State Review Committee, the Publicity Coordination Committee and the Media Coordination Committee exist, but have not functioned regularly.

Directorate Level : Family Planning is a wing of the State Directorate of Medical and Health Services, and is headed by the Director, Medical and Health Services. The Additional Director of Medical and Health Services (Health) who is in charge of all Health Programmes including M.C.H. is responsible to the Government for the Family Planning Programme as

well. The basic idea has been to bring about larger involvement of the Medical, Health and M.C.H. personnel at all levels with the Family Planning Programme. The State Family Planning Bureau having six functional divisions is the nerve centre for all activities of the Family Planning programme. The chief of this Bureau is of the rank of Joint Director, assisted by two Deputy Directors (Programme and Training), two Assistant Directors (Programme and MCH), an Education Officer, one M.E.M. Officer, and an Administrative Officer and the Demographic Evaluation and Statistical Officers.

Regional Level : After continual representations, the Government of India have sanctioned only five Regional Assistant Directors (one for each of the two revenue divisions) and a Deputy Director for the selected area division for regional level supervision. These officers have no other assistance. The State Government is considering to widen the scope of activities of the range Assistant Directors borne on the Health Budget of the State, by including family planning supervision also as a part of their function. This would result in better supervision over a smaller area.

The Commissioner of the Division is the Chairman of the Divisional Family Planning Committee for reviewing the performance and coordinating the activities. These Committees meet regularly and take an overall view of the progress.

District Level : The responsibility for managing the family planning programme rests on the District Medical Officer of Health and Family Planning in rural areas and on Civil Surgeons in urban areas. The District Officer coordinates and directs the programme in the whole district with the help of the Additional District Magistrate (Planning), and also is the Chairman of the District Family Planning Advisory Committee. The responsibility of Family Planning work having been placed on the District Medical Officer of Health and Family Planning for rural areas, it ensures complete integration of Medical, Health, M.C.H. and Family Planning activities at the District and P.H.C. level because, the D.M.O.H. and F.P. also controls the administration of P.H.Cs. Similarly, the involvement of Civil Surgeons for Family Planning work in urban areas ensures the cooperation of medical services at the District level.

Primary Health Centre Level : Because of the shortage of doctors, there is only one Medical Officer instead of two at each Primary Health Centre at present, and he is in charge of medical care, Health, M.C.H. and Family Planning programmes for each Primary Health Centre, catering to a population of 80,000 to 125,000 in the plains areas. The Medical Officer, Primary Health Centre administers the M.C.H. and Family Planning programme through one Block Extension Educator, four Family Planning Health Assistants (Males), one Health Visitor and 10 Auxiliary Nurse-cum-Midwives (ANMs)/Family Welfare Workers (FWWs) (four of the ANMs are on State Health Budget whilst 6 are being paid from Family Planning

Budget) in his area. The scheme of posting two health visitors and all 10 female workers as trained ANMs could not yet be implemented due to extreme shortage of these personnel.

Training : The key trainers of the seven Regional Family Planning Training Centres are trained at the Central institutes, whilst, all field personnel are trained at the seven RFPTCs. Since the training load is heavy, the Central Family Planning Field Units of Government of India provide training in family planning to the Health Visitors, ANMs and PWWs. The training of Health Visitors is carried out by four training schools and of ANNMs by 22 ANM training schools in different regions of the State. The number of ANM training schools is expected to be increased by another 10 with the help of UNICEF within this year.

Personnel Administration : Appointment, posting, transfers and disciplinary powers have been decentralized as far as possible, and, further decentralization is also being considered by the State Government to improve managerial aspects. The State Government is involved only in appointments of gazetted staff and medical personnel, whilst the Director of Medical and Health Services appoints the Extension Educators and clerical staff. The appointing authority for ANMs is the Assistant Director, M.C.H., for FWWs it is Regional Assistant Directors and for Family Planning Health Assistants, it is the District Officer. But in a State with a fairly vocal democracy, interference at the instance of representatives of the people, even in regard to the non-gazetted staff is not uncommon.

Recruitment of family planning personnel for peripheral level is through Employment Exchange by selection committees at various levels. The programme suffers from shortage of doctors, particularly female doctors, Health Visitors and trained ANMs.

Targets and Methodology of Work

The targets as allotted by the Government of India are distributed in the form of yearly and monthly targets to each district and urban area, the main criteria being the population and geographical condition.

The methodology of work on Extension Education lines has been clearly laid down and widely circulated with specific job responsibilities of each functionary. This methodology is also the basis of all training curriculum. Since the population of 20,000 given to a F.P.H.A. was considered to be unapproachable, he has, with effect from June 1969 been assigned a population of 10,000 only for *intensive* work according to a predrawn calendar using interpersonal and group approach and acceptor-leaders for motivating the couples. The ANMs and FWWs have similarly been assigned a population of 5,000 each for family planning work. The new plan of operations for 1971-72 has given greater flexibility in working, whilst ensuring preparation of Target Couple Registers for the total population.

The Revenue and Community Development workers have been involved through the District Officer and Additional District Magistrate (Planning) and they have been specifically given the task of motivation from amongst the remaining non-intensive area population. Efforts to involve the school teachers in rural areas have been continuously made at district level and through instructions from the State Education Department. The State government is considering a special incentives scheme which may further enlist their support.

Efforts are made at all levels to get the support of leaders and voluntary agencies through seminars and training programmes.

Financial Administration

The Commissioner-cum-Secretary, Medical, Health and Family Planning has been empowered to sanction the funds for continuing schemes within the itemwise sanctions given by the Government of India. The budgetary sanctions are operated by the Joint Director-cum-State Family Planning Officer at State level, by the District Medical Officer of Health and Family Planning at the district level, by Civil Surgeons for the urban set-up and the Medical Officer incharge, Primary Health Centre for staff at Primary Health Centre level.

Building Construction

Only 477 Primary Health Centres out of the 875 for the State have buildings of their own, the remaining being run in rented buildings. The construction programme for Family Planning main centres and sub-centre is being carried out by the State Public Works Department on the pattern provided by the Government of India. The construction programme has not picked up the necessary momentum, the chief reason being the dependence on the Public Works Department in carrying out the works. Efforts to solve the problems are being made. The lack of suitable buildings for the Primary Health Centres has been a great drawback in the programme.

Supplies

Powers for purchase of supplies except for Nirodhs have been delegated to the districts, subject to the store purchase rules. The Nirodh supply is maintained by the Central Medical Stores depot on the indents placed by the D.M.O.H. and F.P., Regional Officers and State Family Planning Officer.

II

Progress of Family Planning Programme : An Overview

The annual progress as regards sterilisations, IUCD insertions and

couple years protected through conventional contraceptive distribution is indicated in Table 1.

TABLE 1

	Sterilisations (in ooo's)		IUCD insertions (in 000's)	Couple years protected through C.C distribution (in 000's)
1965-66	76.24	2.26	45.34	61.61
1966-67	79.43	3.15	106.46	42.37
1967-68	159.16	4.91	103.04	55.73
1968-69	155.88	6.18	90.79	116.25
1969-70	78.11	8.75	81.15	168.06
1970-71	77.89	10.84	96.74	174.79

The initial clinic approach was changed over to 'Reorganised Extension Approach' from 1964-65 and reinforced by introduction of IUCD as a method of contraception from 1965-66. The expansion in programme inputs from 1964-65 was accompanied by a marked increase in performance for five years, after which the achievements in sterilisation and IUCD suddenly dropped down. But, it is accompanied by an increase in conventional contraceptive users. There is a positive correlation between the high sterilisation achievements in 1967-68 and 1968-69 with the intensive propaganda, staffing of urban and rural centres, supply of equipments, increased use of mobile sterilisation units and high degree of involvement of Revenue and Community Development Department workers in motivating cases for sterilisation.

There is a steady rise in tubectomies year after year. Tubectomies accounted for 3 per cent of total sterilisation in 1965-66, whereas it forms 13 per cent in 1970-71, which points to the increasing acceptance of programme by women.

In IUCD insertions, the initial rise in the year 1966-67 and 1967-68 was followed by a drop due to well-known reasons, but, it gradually seems to be rehabilitating itself from the year 1970-71.

VARIATIONS

U. P. seems to have many variations in the achievement of the targets. Evidence of it is available not only from yearly achievements, but, also from achievements within divisions, within districts and within different areas of the same district. The pattern of acceptance of the contraception methods by rural and urban people, people of different religion, castes, socio-economic conditions, ethnic groups and literacy have no uniformity and these patterns differ from time to time. The depth studies in U.P. could

be not only fascinating, but are also necessary for the betterment of the programme. Unfortunately, the present evaluation activities of the State are mainly devoted to the assembling of data and preparation of reports, for want of adequate resources. However, the State has approached the International Institute of Population Studies, Bombay, and other independent institutes to conduct the required studies for suggesting a practical solution to our varying problems.

The yearly variation in achievement of sterilisation as rate per 1000 population amongst various districts in the last 5 years has been between 0.10 to 5.66. This is also reflected in the range of variation in cumulative achievements in sterilisations since inception to 1970-71 which is 3.0 to 22.5 per 1000 population. The State per thousand coverage in cumulative achievement in sterilisations since inception is 8.0.

Sterilisation appears to be more popular in hill districts, as against IUCD which is least popular in these districts. Only 5 districts can be credited to have maintained a sustained level of high performance for 3 consecutive years during last 5 years—4 out of these 5 districts are hill areas. Eight other districts have appeared twice only within the ten high performance districts during the last 5 years. Whilst all hill districts have achieved one of the first ten positions either once or more during the last 5 years, no district of one particular Division has ever appeared amongst the first ten districts. All of the 54 districts, except five, have in some year or the other achieved high rates of sterilisation during the last 5 years, but the five laggard districts are neither geographically contiguous, nor different in staffing pattern. The neighbouring districts have given high performance at least once during the last 5 years.

The State coverage in cumulative achievement of IUCD insertions since inception to March 1971 has been 6.0 per thousand population, with a variation in districts from 0.6 to 13.7. At least five districts have consistently been motivating a high number of cases per 1000 popluation over the last five years and they are geographically far apart and different in every other aspect. By and large, it can be said that the achievement in IUCD insertions is comparatively poor in Hill districts and Eastern parts of the State. Whether it is due to the availability of resources for IUCD, or due to other factors in population should be a matter of depth study. One predominant factor in lower achievements of IUCD in State (at the All-India level, the State has done considerably better work in IUCD than in sterilisation) is extreme shortage of female doctors, and female personnel employed for motivational purposes, thus limiting the service to 5–7 Primary Health Centres of a district.

The conventional contraceptives are mainly restricted to distribution of Nirodh and motivating couples for regular use of it. The number of Nirodhs sold through commercial distribution is not known. Yet, a steady progress is being maintained in spite of an interrupted supply position.

Departures are commonly evidenced in acceptance of Nirodh for regular use and its variation is from person to person. It could, however, safely be said that it is accepted more by literate and urban population.

From the data available, specific variation and its causes are difficult to pin-point in all the 3 methods of contraception. Possibly, the proposed studies may reveal some correlation between different factors.

70-80 per cent of sterilisation operations and IUCD insertions are performed in the months of September, December and March, which periods correspond to the National and State drives organised with the help of the three main Government Departments, namely, Health and Family Planning, Revenue and Community Development. The total yearly achievements tend to fall if at any time any of these drives are not organised, as it happened during March 1971 when, due to parliamentary elections and census work, the March drive could not be organised. The achievement in March 1971 in sterilisation had a slight fall even when the achievements till February 1971 were more than those for the corresponding period of the year 1969-70. The large number of tubectomy cases and IUCD insertions in 1970-71 are a pointer to the sustained motivation amongst the female population. It appears that the drive spurts are almost always preceded or followed by the hibernation of the activities of family planning field staff, and thus, the momentum gained during the drive is not continued over the succeeding months. There is, however, evidence of increased motivation activity in vasectomy operations by family planning workers when the agency-wise participation is analysed, over the last 5 years. Cases for tubectomy and IUCD are wholly motivated by the medical and family planning personnel.

An analysis of urban/rural break-up of sterilisation and IUCD insertions shows that whilst the percentage of sterilisation is increasing in urban areas, the reverse is the trend for IUCD.

III

Some Problems of Administration in Uttar Pradesh

Involvement of Agencies

In my view, in a populous and relatively backward State like U.P. beset with traditional orthodoxy, the Family Planning programme in the earlier stages, at least, must be treated as a comprehensive whole and placed on a 'war footing'. What are the elements of the execution of a programme on a 'war footing'? It means a multi-pronged attack and involvement of multi-agencies as well as all shades of public and political opinion. I sincerely feel that the norm of a small family is not attainable unless the problem is treated as a complex social problem, not to be left to the solitary

care of the Public Health or the Medical Department only. All the agencies working in the field, particularly those relating to development and impinging on the economic life of the community, have got to be involved. It has been our experience in Uttar Pradesh that until there is a total mobilisation of administrative efforts and unless traditionally effective hierarchies are used in furthering the programme, the *initial* tempo and momentum that is so badly required, cannot be gained. The Community Development staff are much more acceptable to the people where extension work is involved. I am, therefore, wholeheartedly for the use of the Block Extension agencies, primary school staff, the staff of the Harijan and Social Welfare Department in this work in the initial stages. In the present socio-economic set-up with still a hangover of feudal elements, it would not be wrong to take the help of agencies which wield some influence socially and economically. These are the agencies with which the villager has been traditionally associated, *viz.*, the Revenue in the past, and, ni recent years, the Community Development and *Panchayat Raj* agencies. The family planning worker is handicapped at present in this regard. He is not adequately trained. More often, his origin is urban. His educational background is also not conducive to the establishment of a persuasive rapport with the rural population. Until, therefore, the family planning worker is more acceptable in the rural areas, he cannot become an effective and efficient instrument for the vast motivational and educational effort that the programme demands. In fact, such persuasive methods were made use of in the earlier "attack" phases of the eradication of plague, malaria and small pox. It is easy to realise that a thought carries more conviction if it is repeated through various agencies. There are at the moment 2,12,000 primary school teachers spread over the villages of Uttar Pradesh and, if each of them were to motivate even one couple in a year, we would be able to get yearly over two lakh cases. This would not be insignificant. The use of the primary school teachers has been tried by us with some success in some of the districts. The only incentive offered was the offer of posting to a place of choice in case he is able to give us five cases.

Role of the Primary Health Centres

While emphasizing the need of the involvement of other agencies, I do not want to minimise or undermine the role of the staff at the Primary Health Centre-medical and para-medical. They are the most useful point of contact with the rural masses and it is on the *quality* of their services that a great deal of motivation would depend. An ailing person would easily listen to their advice. In a way, it is the Primary Health Centre which is the primary unit of 'conversion' for a change of behaviour. In the recruitment of medical and para-medical staff, care has, therefore, to be taken to select people with special aptitude for conversion or persuasion.

Thus those not suitable for this type of work must give way for others. It is here that the difficulty comes in. We have found it difficult to get rid of such unsuitable workers, because of pressure tactics and general opposition to the termination of services of such reluctant staff.

Infrastructure

This brings me to another point, *viz.*, improvement of the quality of the services at the Primary Health Centres. In our State, the Primary Health Centre has a limited budget for medicines or equipment. The State resources and the State's own commitment in other important projects, like Power and Irrigation, would not admit of any increase in allotment to social services, particularly Health. In the Fourth Plan, it is only 3 per cent of the total Plan outlay. Part of it is already committed to schemes of medical education, building of hospitals and dispensaries. The result is that in matters of medicines and equipment, the Primary Health Centre continues to be neglected. While Health is admittedly a State subject, I am convinced that if the Family Planning programme has to make a headway, the Centre must come forward to help the States in a big way in improving the quality of service at the Primary Health Centres. It could be in the shape of equipment, conversion of some Primary Health Centres into four-or six-bedded mini-hospitals and the provision of ambulance-jeeps to some of these Primary Health Centres. In a note regarding assistance to be provided by the World bank, we have suggested this. I would, however, urge that the Government of India may, if need be, come forward with a promise of assistance for increased allotment of medicines and maternity beds for Primary Health Centres.

Personnel Selection

The question of determining the method of selection of workers has vexed the mind of many administrators, particularly, in view of the spreading indiscipline and low output of work. A recent study in U.P. shows that 48 per cent of the workers do not follow either the calendar of work or the methodology; 30 per cent do not stay in the area assigned to them; 20 per cent did not motivate any couple for any method in 9 months; another 20 per cent motivated only 1 couple and 40 per cent motivated only 2–5 couples during this period. It is true that the workers in a particular area or working with some hostile ethnic groups may face resistance. But, the success of another worker in an immediately adjoining area confirms the belief that it is only a well-trained and well-motivated worker with faith in the programme and an attitude favourable to social work, who can be successful to promote the acceptance. The U.N. Mission, as well as the Central Family Planning Council, have stated that the practice of treating the family planning personnel as "temporary" is a handicap to

recruitment and an obstacle to the development of a career service and have recommended that a plan for development of careers in family planning work should be formulated to attract the ablest persons and service conditions made more favourable. Recently, the Government of India have recommended to State Governments to consider conversion of 30 per cent key posts into permanent ones without taking any financial obligation on this account. The State Governments would naturally hesitate to accept it because, neither the "key posts" have been defined, nor, would it be possible for most States to add to their financial burden. The basic question still remains unanswered. One hopes that the future graduates with population-education as content of their studies may prove better in delivering the goods and security of service may prove to be an incentive.

Facilities to Staff

One of the deficiencies in the programme is the lack of facilities provided to the personnel both in regard to residences as well as movement in the areas of their charge. The army or the police marches with all the equipment needed. So do the workers in important projects, such as dams, canals, or other industrial projects. But while the Family Planning Programme is conceived as a giant programme, nothing has so far been done to provide even elementary facilities to the staff working at the base level. The success of the programme depends on interpersonal contacts and frequent movements. How can we expect them to live and move in rural areas where facilities of food and shelter are not easily available? Understandably, they shirk and sometimes do only 'paper' work. In the Revenue administration, when *Kanungos, Naib Tehsildars, Tehsildars* and Sub-Divisional Magistrates move out in camps, they are provided all facilities of transport and kit. The Family Planning worker has to be in the field all the time. He does not do a less onerous job than a revenue official and I see no reason why attention should not be paid to this aspect of his living conditions, particularly in case of the female staff employed in the work.

Administrative Assistance

We have for long depended on the Primary Health Centre doctor to be in complete charge of the operations in his area. Owing, however, to the lack of proper facilities, the Primary Health doctor has not yet acquired the necessary administrative status or confidence that will induce the people to change their fertility behaviour, but if we could post an Administrative Officer under him, I am sure the programme would make a better dent. The type of the Administrative Officers I have in view, are officers akin to Block Development Officers. They have the necessary experience, the backing and the confidence of the progressive people in the Block. I would, therefore, plead that as an experiment we may try some of the Block

Development Officers as Block Development Officers (Family Planning) in a Block. I have not the least doubt that once these functionaries are injected into the organisation, the results would be tremendous.

Leadership

There is the question of providing the proper leadership for the successful implementation of a programme of this magnitude. The district is still a vital unit of administration and it is my considered view that the District Magistrate is the only person competent to provide such a leadership. The success of the programme depends on the interest that he is able to take and the time that he is able to devote to such a programme. In the case of Uttar Pradesh, we found out particularly that among the districts that did well, the single factor successful was the leadership and team spirit provided by the District Officer and even though the District Officer is burdened with a large number of functions, I would still plead that Family Planning should form an essential part of the District Officer. He commands respect and great influence. A large personnel belonging to various departments and various other auxiliary services, such as vehicles, buildings and infrastructural material, are at his disposal.

Motivation Camps

One of the ways to make the scheme popular and the motivation effective, is to have "group motivation camps" of, say, three days' duration where we could bring couples of various communities to live together and discuss the social aspects of the programme. The group would comprise some persons who have taken to family planning and would transmit their experience to those who are either shy, indifferent, unwilling or reluctant to take it up. While it is true, that there is a little awareness, there is still a good deal of ignorance about the methods and fear of repercussions on the health and safety of the couple. Many of these misgivings are bound to be removed, if people of a particular age group from nearby localities are kept in a common place for, say, two or three days where they could live and mix freely with some satisfied couples. The camp could include besides the customers—satisfied and reluctant—some social scientists, medical men, auxiliary nurses and midwives who could in a very informal manner, remove many of the misgivings about the programme. The camp of, say, 20 such couples, three-four medical/para-medical men for a period of three days would be far more effective than the audio-visual mass media.

Reorganise M.E.M. and Interpersonnel Approach

The information education effort is impressive in its quality, its variety, and its use of many media year after year. It is, however, as yet

deficient in contents, only sporadically going beyond information and instructional themes. For a long time दो या तीन बच्चे बस, अगला बच्चा अभी नहीं, हम दो, हमारे दो slogans have been prominent. But so far no concerted, comprehensive or cohesive plan has been drawn up to instil the small family ideal in young couples or to reduce the preference for sons. A changed outlook and plan in direction of MEM activity is badly needed. More attention needs to be given to determining educational needs, to fact-finding about the audiences to be reached and to a more systematic MEM programme planning. An action strategy based on interpersonal approach has to be evolved, to enable the field workers in the prosecution of the family planning programme. Obviously, no single approach could be applied to differing communities and peoples in different regions, but tested guidelines can be provided to the workers to make extension approach more meaningful and bear results. This is an area which demands large scale communication and research studies.

Shyness of Voluntary Agencies

The role of semi-governmental and voluntary agencies as well as of "strategic groups" like political decision-makers, employers and employees' organisations, medical and nursing professions, teaching profession and various organised clubs, etc., in creating favourable public opinion on social reform aspects of the family planning programme and stimulating community action, has been amply stressed by the Government of India, as well as State Governments. In fact, such organisations are better geared to motivate, because of the prestige, influence and flexibility that they enjoy. In spite of multiple efforts made and seminars, conferences and training courses held, nothing much has yet been achieved by way of positive results. It is necessary to analyse these groups and their attitudes.

The 'Twilight Gap' : An Area of Research

A number of studies in India have revealed that whilst there is a wide awareness in the public and interest of large majority of people in the family planning programe, only a small minority have taken steps to limit the family after intensive interpersonal and group approaches. The causes for this 'twilight gap' between awareness, interest and the final adoption has not been a subject of serious study and this gap in knowledge seriously affects implementation. Even today, the group leaders in these small isolated communities—castes and sub-castes—dominate and hold public opinion on almost all issues—social and economic. Continued and concerted research needs to be carried out among such smaller groups in order to study their patterns of behaviour and factors that would motivate a change. In the present family planning programme, I see no evidence of such research and I would sincerely plead that small research groups should

undertake such research on group behaviour among such communities. We have to determine exactly what incentives, disincentives, compulsions or satisfaction of personal needs and aspirations in differing socio-cultural economic backgrounds could be utilised to shorten the 'twilight gap' and lead the people to accept small size family norm. The findings could be fed back in the training curriculum.

Conclusion

Our studies show that the phenomenon of high and low performance in targets set for the three methods has a close association with the contribution of family planning personnel, and also with the quality of supervisory and administrative tiers, capable of generating leadership and obtaining cooperation from other departments. An adequate administration, oriented in managerial techniques, well-trained workers with proper attitudes and faith in the programme, an adequate infrastructure and a well-coordinated programme with allied Government and voluntary agencies, with the normally expected flexibility in budgetary control, can be the best guarantee to the eventual success of the programme. Given the above conditions, it could be safely presumed that the programme will have a successful take off from the present position, even against the heavy odds of socio-economic, cultural, educational and other factors existing in the State at present.

Family planning involves a social change. The change we desire, the change which must come, is not merely one of pace or quantity but of basic quality as well. The preoccupation with smaller day-to-day problems should not cloud a careful examination of the policies, issues and assumptions.

The Prime Minister said the other day that "we have allowed our growth to be inhibited by structural and other difficulties—an outmoded social system and attitudes of mind, an administraive machine which has been devised by foreign rulers for their own purposes. Many of the difficulties are inherent in underdevelopment". Our administrative patterns must conform to the changes needed. Let it not be said of us that we know the price of every thing and value of nothing.

Our task is to build on the experiences of the past, which is the precursor of the future. The future is to be determined by our actions and ability to develop a science and a philosophy of family planning administration and a pragmatism competent to discharge all functions and ensure for the people a life worthy of the noble status of mankind.

ADMINISTRATION OF FAMILY PLANNING PROGRAMME IN MAHARASHTRA

DR. N. H. KULKARNI*

Introduction

The galloping rise in population is a serious threat to the policy and ideology of a Welfare State. Economic development, rise in the per capita income, adequate nourishing food, are basic prerequisites for the welfare of the people. These cannot be achieved in the present era, unless radical and drastic measures are adopted to stabilize the population within the shortest possible time. In this context, family planning must be considered as an important sector of the country's economic development plans.

Maharashtra is one of the pioneer States in the field of Family Planning. As a State policy, Government of Maharashtra (the then State of Bombay) commenced Family Planning Programme from November 14, 1957 falling in line with the national policy. But it is worth noting that the real seeds of this concept were sown in Maharashtra as early as 1928 by the late Prof. R. D. Karve. A Birth Control Clinic was opened by him in Bombay and he also published a magazine *Samaj Swasthya* and tried to popularise the message and ideology of Family planning among the people. In 1936, Dr. A. P. Pillai conducted a Family Planning Training Course in Bombay. Later, the Family Planning Association of India came on the scene with more scientific and a direct approach in 1952.

In the early years of this programme, the approach was cautious, hesitant and did not produce much by way of results. During the second five year plan, the approach was more clinical. It was thought that by opening more and more clinics, people would become more interested. But it fell short of expectations as the message of family planning had not reached the people.

Towards the latter part of the third five year plan, 1965-1967, there was a spurt in the activity and some impressive results were seen due to the sudden popularity gained by IUCD (Intra-Uterine Contraceptive Device). This was, however, very short-lived and IUCD unfortunately went into disrepute for various reasons. It was olny after the introduction

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of the Extension-Oriented approach that Family Planning Programme really gained ground in Maharashtra.

Population Policy of Maharashtra

The Government of Maharashtra was very much concerned and anxious about the programme because, in spite of ten years of work, family planning had not really caught the imagination of all the strata of society. The cabinet of Ministers, therefore, took stock of the situation, discussed the question threadbare and took certain momentous decisions in July, 1967. Maharashtra announced a very radical population policy and determined to bring down the birth rate from 38 per 1000 to 25 per 1000 population by 1976. The oustanding features of the radical policy were as follows :

1. Total and complete involvement of *Zilla Parishads;*
2. Sterilisation, a mainstay;
3. Withdrawal of certain concessions to people who do not limit the size of the family beyond three children with effect from August, 1967;
4. Increase in the payment of out-of-pocket expenditure given to the promoter and increase in the compensation to the volunteer; and
5. Doing away with certain categories of staff.

Special Features of Family Planning Administration in Maharashtra

For quick and effective implementation of the State Policy, a post of Commissioner, Family Planning, was created. The Deputy Secretary in charge of the subject of Family Planning was appointed as the Commissioner for Family Planning from October 1, 1967. Wide powers were given to him for quicker implementation. Later, since June, 1970 the Secretary to Government, Urban Development, Public Health and Housing Department, has taken over as the Commissioner for Family Planning in addition to his normal duties. The Secretary and Commissioner has special financial powers whereby he is authorised to sanction schemes and finances directly without making reference to the Finance Department so far as family planning programme is concerned. This has positively helped to cut down the delays and the red tape normally associated with Governmental procedures.

Another noteworthy feature of family planning programme was the policy of decentralisation. The programme was given over to the *Zilla Parishads* on agency basis at the district level and they were made responsible for the execution and implementation. *Zilla Parishads* are run by the elected local leaders and, therefore, influence people more effectively. This policy of decentralisation certainly boosted up the programme. In many districts of the State, because of local involvement, it became

a 'people's programme'. A major share of the success, particularly in sterilisation work, goes to the local leadership. Where the local leadership was not effective, the programme did not catch up.

It is the policy of the State Government to treat agriculture, family planning and small savings on equal footing. All departments of the State participate in the programme. District Officers like the Collector, the Chief Executive Officer of *Zilla Parishad,* District Health Officer, District Agriculture Officer, conduct joint tours to educate and convince the people of the interdependence of these three vital programmes.

Family Planning Programme is now a 'Community Oriented' programme executed through the *Zilla Parishads* at district level. There are 25 *Zilla Parishads* in the State. These in their turn work through the village *panchayats* and there are 21,334 *panchayats* in Maharashtra. The *Sarpanches* along with local leaders in the rural areas are helping to carry out educational activities, organising camps, motivating people for sterilisation and use of conventional contraceptives. The *Gram-Sevaks,* Teachers, who work under the Rural Development Department at village level and *Talathis* under the Revenue Department also assist in the programme. Local Bodies (Municipalities) and Voluntary Organisations are also involved in the programme and many of these are doing very good work.

The 'cafeteria approach' sponsored by the Government of India has been accepted and followed in Maharashtra. However, the major emphasis has been laid on sterilisation, since the beginning of the programme in the State. Till March 1971 as many as 14.11 lakh sterilisations (male and female) have been performed giving an overall cumulative rate of 27.95 per 1000 population as against an all-India rate of 15.2 per 1000 population. The success so far achieved in the State can be mainly attributed to the following :

1. Involvement of local leaders,
2. Incentive schemes, awards, etc.,
3. Helper Scheme

Earlier, it has been explained how the scheme has been implemented through *Zilla Parishads* on agency basis and how the local leadership is involved.

After the momentous decision on population policy in August, 1967, the incentive to one who promoted a case for sterilisation was raised from Rs. 2 to Rs. 10 for vasectomy and Rs. 7 for tubectomy.

State Awards—Incentive Scheme : To create a sense of healthy competition and give a fillip to the sterilisation programme, the State Government introduced a scheme of giving awards each year to honour all people who rendered valuable services.

Presidents of *Zilla Parishads* and other non-officials as well as officers *viz.*, Chief Executive Officer, District Health Officers, Civil Surgeons,

Block Development Officers, Presidents of Municipalities, etc., as well as best motivators and helpers were given awards for their best performance on yearly basis.

All these State awards were given in colourful functions presided over by the Governor of Maharashtra.

Awards to Best Panchayat (Long Term Motivation Scheme)

Cash awards of Rs. 20,000, Rs. 15,000 and Rs. 10,000 were given to the first 3 blocks in the State for the best performance on a two years' cumulative progress.

Scheme of 'Kutumb Kalyan Gram Gaurav'

Cash award (one rupee per capita) was given to any *panchayat* doing maximum cumulative performance of sterilisation in each district.

Zilla Parishad Awards

Several *Zilla Parishads* give away special awards and prizes to different peripheral workers as incentives for good performance each year.

In August 1967, posts of Extension Educators at the block level were abolished and, instead, a Helper Scheme was introduced in the State. Any person who motivated a case for sterilisation was given cash incentive on per case basis. This gave a sudden fillip to the sterilisation programme and in 1967-68, 3.32 lakh sterilisations were performed. This performance in one year was even greater than the previous ten years' performance.

Administrative Organisation—Maharashtra State Level

The Minister for Public Health is assisted by the State Family Planning Board.

The Secretary to Government, Urban Development, Public Health and Housing Department and Commissioner, Family Planning heads the organisation and is assisted by the Deputy Secretary. A separate Family Planning Cell is created in the Secretariat for prompt and efficient work.

A full-fledged publicity wing and a demographic and evaluation cell is functioning under the direct control of the Commissioner of Family Planning at Bombay.

The State Family Planning Bureau is functioning with its Headquarters at Poona. The powers of the Commissioner, Family Planning, have partly been delegated to the Jt. Director of Health Services (Health), Poona, who is stationed in Poona. The Deputy Director of Health Services, Family Planning, M. & C. H. and School Health, is the head of the State Family Planning Bureau. He is assisted by one Assistant Director of Health Services, Family Planning. The Bureau works under the overall guidance

of the Commissioner, Family Planning and Jt. Director, Health Services.

Recently, one post of Executive Engineer has been created under the State Family Planning Bureau, Poona, for the construction works under the programme.

Divisional Level

The State is divided into seven circles and each circle is headed by a Deputy Director of Health Services, who supervises and guides the programme in the respective districts under his administrative control.

In addition, there is one Assistant Director of Health Services, Family Planning, in one of the divisions, namely, at Nagpur, for intensive supervision of Family Planning work and also M.C.H. There are two more Assistant Directors of Health Services of M.C.H. one with the Headquarters at Poona and one at Nagpur who also supervise the Family Planning and M.C.H. work.

District Level

The district is a basic unit of administration for all practical purposes. It is a "functional unit". The District Health Officer heads the district organisation and is assisted by an Assistant District Health Officer (F. P. and M.C.H.). The district organisation is a part of the *Zilla Parishad* and works under the direct administrative control of President of *Zilla Parishad* and the Chief Executive Officer.

Peripheral Level

A Rural Family Planning Centre functions for a block and is usually associated with a Primary Health Centre for the block. Each combined unit of Primary Health Centre and Rural Family Welfare Planning Centre has six to seven sub-centres. The peripheral worker at the sub-centres is an Auxiliary Nurse Midwife or a Female Field Worker and normally covers a population of ten thousand (10,000) in the rural areas.

Family Planning Administration Prospective View Point

Family Planning Administration is one of the newest branches of administration. It comes under the purview of both 'health administration' as also the 'development administration'. Population control is a national goal as a means to social, cultural and economic prosperity and as such it must receive top priority attention from the State Governments and they should make it an important wing of the development branch of administration.

Family Planning Programme is to bridge the gap as also balance the economic growth with the population, thereby help to raise the per capita

income and give the people a higher standard of life. If this is accepted, there is need to give it a direct economic and development orientation. Population control being a challenging issue, considerable imagination and innovation is necessary in this special field of administration. To-day, it is a centrally sponsored programme and will remain so for the next 10 years and the entire expenditure will be met by the Central Government. The Government of India lays down broad policies and patterns for the development of the activity and the State Governments are expected to carry out the implementation within a framework given by them. There is a certain degree of rigidity which needs to be reviewed and made more flexible. The State should be able to modify the programme as they wish. There is plenty of room for innovation in the policy and implementation of the programme. It is very encouraging that the States are not burdened with the responsibility of finding resources and hence, the States can concentrate their energies on implementation of the programme. But some major disadvantages, in the present system of Family Planning Administration need to be rectified. The States must have a larger scope for financial and administrative flexibility to modify the programme to meet their requirements keeping in mind the demographic, economic and social situation in their own States.

The expenditure on family planning is a part of the plan expenditure and the programme is considered as temporary. All the personnel employed under the programme are treated as temporary and, therefore, cannot enjoy the rights and privileges of permanent staff. This is a handicap and obstacle in the development of a career service. To assure the personnel some future, it is very necessary that Family Planning is treated as a permanent scheme and 80 per cent of the posts must be given a permanent status. Unless there is security of service for the workers, the performance may remain below par. Hence, there is urgent necessity to treat this programme on a permanent basis and allow the States to make 80 per cent of the posts permanent.

The Family Planning Programme is a very important national activity; it has to be constantly reviewed, assessed and modified from time to time to suit the prevailing conditions to make it more dynamic and effective. Certain administrative modifications referred to earlier need to be considered for making the organisation broad-based for the effective implementation of the programme and attaining the goal of population control within as short time as possible.

ADMINISTRATION OF FAMILY PLANNING IN BIHAR

N. P. SINHA*

The world population is currently growing at about 2 per cent per year. This world average has two very different components, each of which constitutes a population problem. For the developing regions, the problem is essentially one of the growing numbers that are thwarting economic development plans and frustrating the aspirations of their people for a better way of life. In the economically developed regions, the problem is essentially one of air and water pollution, depletion of the natural resources, and a general threat to the ecology of the earth. Although comparison will be made where appropriate, it is beyond the scope of this paper to discuss in detail the population problems of the developed world.

Current high rates of population growth result from the fact that in the modern era there is a sharp decline in the mortality rate. Because of man's universal desire for health and longevity, institutions and individuals have always supported and adopted measures to ward off death. As a consequence, vaccines, antibiotics, insecticides, and chemical agents developed during and since World War II have been widely applied. The result is that mortality has declined rapidly around the world, and not necessarily in association with social and economic development, nor with a decline in fertility.

Unlike death rates, birth rates are far less susceptible to rapid decline. The mortality rate can be greatly changed by community measures but the fertility rate can be changed mainly by the actions of many thousands of couples. In many developing countries, it is this gap between the unprecedentally low level of the death rate and the traditionally high level of the birth rate (40 to 50 per 1,000 population) that has resulted in high rates of population growth.

The developing nations are currently estimated to become double in 32 years. Morever, it is anticipated that as the death rate continues to decline unless the fertility rate also declines, the growth rate of the developing regions will increase. With 70 per cent of the world's population living in the developing regions, the global growth rate is 2 per cent per year, even though the growth rate in the developed world, is about 1 per cent per year.

*Health Commissioner, Bihar.

As a result of successive Five Year Plans, India has made striking advances in economic and social fields. The ushering in of the Green Revolution has brought about a substantial increase in agricultural production. There has been 150 per cent rise in industrial production. Educational facilities available now are much greater. Communicable diseases like malaria, plague, smallpox and cholera have been eradicated or brought under control.

Expectation of life now stands at 53 years.

Unfortunately the gains of development have been seriously eroded due to the rising population.

The per capita income in India is, perhaps the lowest in the world and Bihar's per capita income of Rs. 292 is not only lower than the National average (Rs. 433) but the lowest in all the States in India.

Health Sector in Bihar and Development Plans

Progress in the health sector during the First, Second and Third plan periods has not been significant. The last fifteen years have witnessed a steady improvement of both curative and preventive facilities. The opening of Primary Health Centres and sub-centres according to a well-defined pattern has brought health care to the door step even in rural areas.

In the First Plan, an expenditure of 9.65 crores was incurred on health care. The per capita expenditure on health, which was only 0.44 at the commencement of the First Plan, rose to 1.03 by the end of the plan. A great effort was made during the Second Plan. The total expenditure was 9.50 crores.

The per capita expenditure on health rose to Rs. 1.43 at the end of the Second Plan. The provision in the Third Plan was Rs. 17.40 crores. The actual expenditure was 15.59 crores. The per capita expenditure rose to Rs. 1.80 at the end of the Third Plan.

The achievement in the Public Health Sector, particularly in the field of control of communicable diseases has indeed been even more impressive. The high priority given to the eradication of malaria and smallpox in the Third Plan has yielded good results. Headway has also been made in the conquest of other communicable diseases. With lesser mortality and more chances of survival, there has been a gradual population growth which went rather unnoticed in the beginning and today we are faced with a situation when the population growth is almost explosive.

In spite of planned economic development in the last fifteen years, Bihar is still lagging behind the rest of the country in the Health Sector.

If Bihar has to liquidate its backwardness and attain the level of development likely to be reached by the whole country at the end of Fourth Plan, a much larger provision would be necessary. However, due to paucity of resources, it may not be possible to make as large a provision in the plan.

Facts about Bihar

Bihar regarded as the cradle of Indian civilisation and culture and one of the seats of mighty empires, is a land-locked State, having an area of 1,74,008 km. between 21.58° and 27.31° north latitudes and 83.20° and 88.32° east longitudes. It is bounded on the north by the Himalayan regions of Nepal, on the east by West Bengal, on the west by Uttar Pardesh and Madhya Pradesh and on the south by Orissa.

The state can be divided physically into two almost equal units, the gangetic plain and the Chotanagpur Plateau. The gangetic plain to the north and south of the majestic river, the Ganga is a flat alluvial tract, having a fertile soil. On the other hand, the plateau region with its elevation ranging between 1,000′ to 4,000′ abounds in hills and forests. The Ganges traversing a length of about 350 miles from the west to the east is the most sacred of Indian rivers.

With only 5.31 per cent of the India's land area, Bihar has 10.3 per cent of the country's population, and is the second largest State in India by size of population.

The present population of Bihar is 56,387,297 according to the latest release of 1971 census figures. In the 1961 census, the population recorded was 48.3 million. Thus, there has been an increase of 8 million in the population of Bihar. This is approximately 2 million less than the anticipated projected population of Bihar which was based on the growth rate.

The rate of growth is 21.3 per cent as against the national growth rate of 24.5 per cent.

Darbhanga and Muzaffarpur are presently the two most populous districts of the State. The present population of Darbhanga and Muzaffarpur is 52,42,250 and 48,36,516 respectively, having 9.3 per cent and 8.58 per cent of the total population of the State.

The average density of population of Bihar is (324) per square km. Population, however, is not evenly distributed. North Bihar is much more densely populated than South Bihar or the Chotanagpur Plateau. Bihar has predominantly a rural population.

Bihar Economy

Bihar's economy is predominantly rural and agricultural. The total area under food crops is 238.83 lakh acres; of this, paddy accounts for 131.25 lakh acres, wheat for 17.50 lakh acres and maize 20.30 lakh acres, these being the three main crops of Bihar.

72 per cent of the people live in villages, 86 per cent are dependent on agriculture for livelihood. About 77 per cent of the total workers in the State are employed in agriculture.

Capital formation is retarded because of low earning. In spite of Bihar being the richest State in mineral deposits, the pace of industrialisation is rather slow.

Changing Social Pattern

Bihar has taken some big strides in the direction of industrialisation. The giant Heavy Engineering Complex at Ranchi (HEC), the Barauni Refinery, the Sindri Fertilizer Factory, the Bokaro Steel Project and similar undertakings have helped to set in motion the process of diversification of State's economy.

As a natural corollary to this, the socio-cultural traits of the people, hitherto regarded as conservative are also undergoing social changes. There has been significant changes in the outlook of the people in respect of age of marriage, inter-caste marriage, property rights of daughters, family structure, etc.

Expansion of education is also playing a significant role in this matter. In the background of crumbling social prejudices and barriers, new winds of change and hope have started blowing.

Administrative Units

The State is divided into four administrative divisions, Patna, Bhagalpur, Chotanagpur and Tirhut Divisions with their Headquarters at Patna, Bhagalpur, Ranchi and Muzaffarpur respectively. There are seventeen Districts and 587 Development Blocks.

There are 67.665 villages and 153 towns in Bihar. Only 200 villages have a population of more than 20,000 each and the towns like Patna, Bhagalpur, Gaya, Ranchi, Jamshedpur, Muzaffarpur and Darbhanga have a popuiation of over a lakh.

Our Goals and Achievements

The objective of our Family Planning Programme is to reduce the birth rate from 39 per thousand to 25 per thousand within a decade. The objective is sought to be achieved by motivation and provision of services to about 10 million couples in the reproductive age group, out of whom about 5 5 million are eligible at any time for practice of contraception. Apart from this group, the other target group is a great bulk of girls who are entering the reproductive age group every year.

The Investment and Achievement

The Government of India has provided increasing resources for the implementation of the Family Planning Programme. The expenditure for 1968-69 (Rs. 370 million) was more than in any previous year and more than the expenditure of Rs. 271.60 million incurred in the first three plans. A provision of Rs. 3,000 million has been made for the Fourth Five Year Plan. As a result of planned work, 13.2 per cent of the 54 million eligible couples in India have been protected by sterilization and IUCD and 1.5 per

cent by conventional contraceptives during 1968-69. The services are being made available through 789 mobile units and 7960 static institutions in addition to 19024 sub-centres of the Primary Health Centres.

Performance

In the year 1970-71, 74,934 sterilization operations have been performed, till March 31, 1971. Since the inception of the programme in 1956, a total number of 4,77,98 sterilizations have been performed.

39855 IUCD insertions have been done during 1970-71. Since the inception of the programme, 1,93,750 IUCD insertions have been carried out.

Conventional Contraceptives : The number of conventional contraceptive users has registered a sharp rise during the recent years. The total acceptors of Family Planning methods have been increasing year after year at the all-India level and that holds good also for Bihar. Based on the analysis made by the total performance and availability of technical field staff, Bihar has not done very badly in the field of Family Planning. The technical staff presently employed in Bihar is not of the required strength.

In the State of Bihar, in the first five year plan, 20 Urban Family Planning Centres were opened and each centre was manned by a L.H.V. An expenditure of Rs. 28 thousand only was incurred.

In the 2nd Five Year Plan, 9 more urban and 22 rural Family Planning Centres were opened. The entire expenditure was only 10.80 lakhs.

In the 3rd Five Year Plan, the total provision was Rs. 40 lakhs. At the Divisional Headquarters, 4 Mobile Sterilization units were opened and an incentive of Rs. 25 was sanctioned for every case undergoing sterilization operation, provided the monthly income of the person operated did not exceed Rs. 150. Five Static sterilization units were opened in 4 District Hospitals. Provision was also made for holding orientation camps for purpose of education and motivation. The total expenditure during the period was Rs. 23.90 lakhs.

Efforts to make Family Planning a way of life for the people started in all seriousness in the year 1964. In that year, a small Family Planning Cell was created at the State Headquarters. The Programme was activised with the functioning of 20 urban and 22 rural Centres. Four mobile sterilization centres at Divisional Headquarters, 10 sterilization units in Sardar Hospital at Dhanbad, Muzaffarpur, Purnea, Hazaribagh, Arrah, Gaya, Sahabad, Daltonganj and Motihari were created.

Extended Family Planning Programme

In the year 1965, at the recommendation of the Mukherjee Committee, steps were taken for reorganising the Family Planning scheme by changing over from the clinical approach to extension approach.

The programme had an immediate appeal to a number of families. Various slogans were coined like "*Do yaa Teen Bache....Bas ! Doctor kee Salah mane*" "*Do yaa Teen Bache Hotah haa Ghar May Acha*". These became more and more acceptable to the people. This is reflected in the methods of contraception becoming popular. Sterilization cannot be practised secretly or in a private room. Implicit in the acceptance of sterilization is not only the consent of the people but a decision of the entire family as also the blessings of neighbourhood and society. Both vasectomy and tubectomy are not confined to the sophisticated clinics but are being done in rural areas also.

Today, there are 107 Urban Family Planning Centres and 587 rural Family Planning Centres, out of which in 310 places there is a doctor in position, meant only for Family Planning.

Administrative Organisation

At the State level a State Cabinet Committee is in existence with the Chief Minister as the Chairman and the Minister, Health and Finance Department as members. It reviews and lays down the policy for implementation of the programme. Unfortunately, it has not been convenient for this committee to meet in the recent past.

A State Family Planning Council has been set up and its job is to lay down the principles regarding Family Planning and to review Family Planning Programme from time to time. It is also to advise the Government on all matters regarding Family Planning.

The working of the Bureau is also reviewed by the State Action Committee which meets every month. It consists of officials from the Department of Finance, Community Development, Public Relations, Rural Engineering, Industries, etc.

A Mass Media Committee with the Health Commissioner as Chairman and representatives from the Department of Public Relation. All-India Radio, Field Publicity, Press Information Bureau, etc., reviews and plans the Mass Media programme. There is also a Grants Committee with the Director of Health Services as Chairman and the Addl. Director of Health Services (FP) and Regional Director (FP & MCH) Government of India as members. It reviews the working of the voluntary organisations and recommends grants to be given to the voluntary organisations.

The Health Commissioner is in charge of the Department of Health and Family Planning. He is assisted in the Secretariat by a Deputy Secretary. The State Family Planning Bureau is headed by the Addl. Director of Health Services (FP). He is the technical Head of the Programme. The flow chart of the administrative set-up may be seen at the Appendix.

At the District Level : D. F.P. O. is head of the District F. P. Bureau. He is of the rank of a Civil Surgeon. There is a District Action Committee

in each district which is headed by the District Magistrate. The District Family Planning Bureau is charged with responsibility of organising and supervising the Family Planning in the District.

At the Block Level : There is one Rural Family Planning Centre in each Block. There is a separate Rural Family Planning Medical Officer in each of the 310 blocks. The Medical Officer in charge of the P. H. C. is looking after the Family Planning work. He has been made the drawing and disbursing Officer of Family Planning Programme within the Block. The Medical Officer of the Block supervises and co-ordinates the Family Planning activities also.

Our Plan

Government of Bihar is trying to make every doctor in the Block responsible for the curative, preventive and family planning programme. It is our endeavour to make the Rural Health services a complex of greater Medical and Health care of the population as a whole. Steps have been taken to upgrade one of the sub-centres in each Block to a fulfledged Family Planning Unit.

The staff employed in the Rural Centres consists of a Medical Officer, an Extension Educator, etc.

One Family Planning sub-centre would be started for a population of 10,000 in each of the centres, with one A. N. M. She will be supervised by the Health Visitors. The Health Assistant Family Planning or Male Family Planning worker is responsible for a population of 20,000 and is responsible to the Block Extension Educator for motivation.

Financing the Programme

The Family Planning Programme is centrally sponsored and centrally assisted; but it is administered by the States. The Programme is not included in the State Plan Ceilings.

The Government of Gujarat have delegated financial powers to the Health Department. They do not have to go to Finance for further sanctions, once the budget is passed. In Bihar, this type of delegation does not exist. Usually approval of the Finance Department is necessary even when the budget is passed.

Coordinating with Other Agencies

Other sister departments like Public Relations, Community Development, Rural Engineering Organisation, etc., are actively participating in the programme. Attempts are being made to involve village school teachers by appointing them as depot holders.

Village level workers who are mainly meant for Agricultural Extension Education are being given orientation in Family Planning through

orientation camps. A few have proved to be good motivators. But this is an area which requires further exploration to ensure their complete participation.

Voluntary and Private Organisations

The Family Planning centres managed by voluntary agencies have men and materials and they undertake publicity, motivation and services like sterilization and loop insertion and distribution of conventional contraceptives. Presently, the State Government is giving grants to 22 such voluntary organisations.

Voluntary organisations are being encouraged for holding camps in rural areas. The main aim of holding such camps has been to help village leaders to know about the aims and objects of family planning and then effectively promote the programme in their respective villages, so that rural families may adopt it as an integral part of their way of life.

Suggestions

1 It will be appropriate to change the name of the programme to Family Welfare Programme as we have the programme of treatment of sterility, child health care, etc. The effect of publicity and motivation then will be far better. Funds should be provided for preventive inoculation and treatment of minor ailments under the Primary Family Planning Centres and sub-centres.

2. It is urged that assistance from Central Government to the States regarding continuance of hundred per cent financing of Family Planning Programme be extended for a period of 25 years instead of 10 years.

In this connection copy of item 5.11(d) "Evaluation of Family Planning Programme" report of panel of U.N. consultants is quoted below.

"Item 5.11(d) Fourthly the Family Planning Programme need to be put on a more permanent footing than the present pattern of financing and Centre-State relations has permitted it to be. The panel feels that the problem of low priority in the States can be greatly eased by provision of clear-cut, written assurance from the Centre about : (*i*) the expected long-term support to the programme, so as to enable continuing commitment of staff in adequate number, and (*ii*) about the readiness of the Centre to cover actual expenditure, on the programme of the level of past performance, so that there is ample scope for expended activity.

The staff employed for Family Planning remain in an uncertain situation regarding their security of service and, therefore, keep on applying for jobs elsewhere, and do not put their heart and soul into their work. This is a natural phenomenon which cannot be avoided in face of recent retrenchment of staff from the various wings of the Health Department like malaria, smallpox, etc., and other sister Departments, *viz.*, Industries, Social Welfare, etc.

3. Bihar has different scheduled, tribes living in the Districts of Ranchi, Hazaribagh, Palamau, Chaibasa, Dhanbad, Santhal Parganas, and some parts of Bhagalpur. Personnel doing Family Planning publicity, motivation and services should be required to be oriented in such a manner that their work does not come in clash with the superstitions, customs and socio-economic aspects, etc. of the scheduled tribes.

A cell should be created in the Tribal Research Institute to give training to workers of all categories for Family Planning in tribal areas, to give them short orientaion in matters of language, the customs, superstitions, religions and socio-economic aspects of the particular tribe where the batch of family planning workers has to work. Funds may be provided to the Tribal Research Institute for this purpose.

4. Government of India have a plan for the construction of buildings for the Regional Family Planning Training Centres and Rural Family Planning centres and sub-centres but they don't have any plan, for the construction of buildings for the State Family Planning Bureaus/District Family Planning Bureaus. In most of the places, suitable buildings to meet all requirements are not easily available but Government land is available. The Government of India have, however, sanctioned a sum of Rs. 2,000 per month for hiring out a building for the State Family Planning Bureau and the Press. The total yearly expenditure incurred as rent is about 24,000 and in 5 years it comes to Rs. 1,20,000. The Government of India has presently sanctioned the continuation of the scheme to another 10 years; that means a sum of Rs. 2.5 lakhs would be spent only for paying rent. The same amount could be utilised for the construction of a suitable compact building of its own for the State Family Bureau. Government of India might consider advancing a suitable sum for this purpose.

5. It is urged that, for proper supervision, the Regional Deputy Directors of Health Services who are in charge of the Division should be provided with a station wagon, an Accountant and a Steno-typist with provision of typewriters and duplicating machines and grants for stationery, etc., to check up the work of family planning and accounts in the Districts of his jurisdiction.

At present in Bihar there are very senior officers working as Deputy Directors in charge of each Division and they are the officers who write the confidential Character Rolls of the Civil Surgeons, the District Medical Officers of Health, and the District Family Planning Officer in their respected divisions, and forward them to the Director of Health Services. They should be made responsible for proper checking of the progress of overall activities and accounts of family Planning in the District of their jurisdiction. They would be able to execute this only if they are made responsible for this work, and, with responsibility, they must have adequate staff, etc. This will help the progress of the work tremendously as they will go into details in the periphery which is not possible from the State Headquarters.

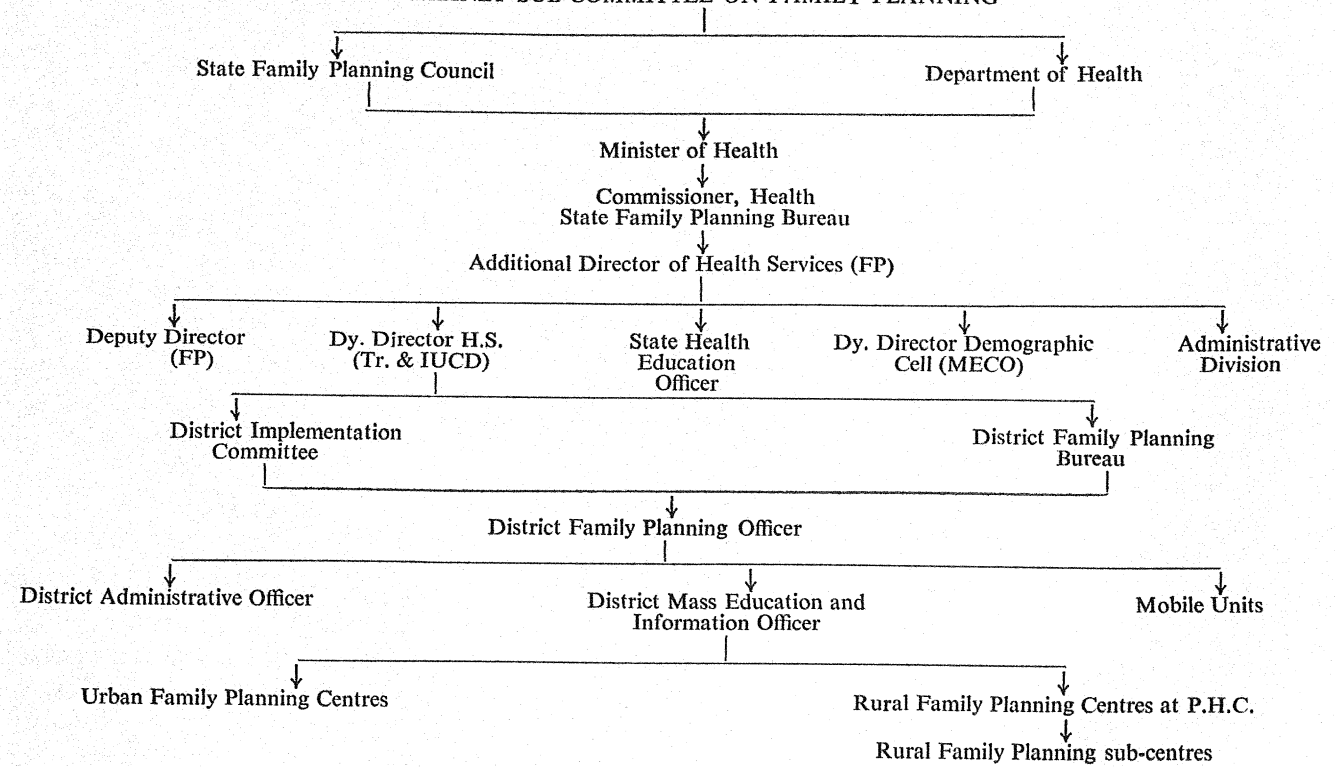
6. In view of the importance of the Family Planning Programme, the key personnel should be carefully selected from amongst those who are motivated to do the work and are likely to remain in their posts for some length of time. The usual practice of selecting personnel on the basis of seniority alone has proved rather discouraging to the programme.

7. A system of evaluating the performance should be undertaken in the District and consequently in the selected blocks. While evaluating the performance, the technical and materials resources, and the cultural factors should also be taken into consideration. The programme may be examined and the strategy may be revised accordingly.

8. There is an acute shortage of A.N.M. in Bihar. The present ratio of providing one A.N.M. for 10,000 population is quite inadequate to meet the growing gulf between the supply and demand. Perhaps, after initial recruitment, such personnel may be given eight to twelve weeks' orientation and then placed in the field.

APPENDIX

FAMILY PLANNING ORGANISATION IN STATE



MASSIVE VASECTOMY CAMPS —AN INNOVATIVE PROJECT IN ERNAKULAM DISTRICT

S. KRISHNA KUMAR*

The Government of India had decided that intensive Family Planning work should be undertaken in 51 selected Districts in the country in phases of 17 each year, selected on the basis of population. Ernakulam District has been selected by the Government of India as the District in Kerala for the first phase of this intensive Family Planning District Programme. It was in the fitness of things, therefore, that the officers in this District decided to take the initiative for a massive drive in the very important programme of Family Welfare Planning. A suitable and novel method of approaching the predominantly rural population of the District with acceptable methods of Family Planning had to be first selected. In order to focus public attention on the programme and provide a rallying point for a popular movement for implementation of the Family Planning Programme, massive Family Planning Camps were visualised as the first step in the drive. Vasectomy operation for men was chosen as the Family Planning method to be popularised at this camp as it is the easiest, surest, permanent method, is less expensive and requires less time, and is best suited to existing conditions of Kerala. The patient undergoing the operation can go home on the same day itself and attend to his normal duties within a few days. Very little time is required for the operation which is performed with local anaesthesia and no hospitalisation being required, large numbers of men can be vasectomised at one camp, if the proper organisation and machinery for bringing them to the camp are built up and a camp with adequate facilities is arranged.

Organisation of The Typical Massive Vasectomy Camp

Appeal by the Collector

An appeal by the District Collector to the general public regarding the importance of the Family Planning Programme in general and the objectives of the Intensive District Programme in particular was issued through the

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Press and through individual letters to prominent persons in all walks of life in the District. The Collector wrote personal letters to different categories of persons and institutions in the District eliciting help and support for various facets of the intensive drive. A meeting of leaders of Panchayats, Municipalities, Factories, Service Organisations, Block Development Officers, Medical Officers and others was also conducted by the District Collector to explain the programme and elicit cooperation for the intensive one month long Family Planning Service Festival.

Formation of Committees

Committees at various levels—Panchayat, Block, Municipalities, Cochin Corporation and the District—were formed for the intensive field work for the drive. The Committees had the following composition :

Panchayat Committees consisted of the representatives of the Panchayat Wards, various Associations of the locality, Family Planning Health Assistants, A. N. Midwives, Village Extension Officers and local leaders. The Panchayat President was the Chairman.

Block Level Committees consisted of representatives from each Panchayat Committee, the Block Development Officer, Medical Officer, Block Extension Educator, Lady Health Visitor/P. H. Nurse and prominent public leaders in the Block area. The Block Development Officer was the Chairman.

Municipal and Corporation Committees consisted of Health Committees of the Municipalities and Corporations, the local Family Planning Staff and prominent public men of the area. Chairmen of these local bodies concerned were the Chairmen of these Committees.

District Level Committees consisted of members of the District Family Planning Advisory Committee, representatives from the Block Level and Municipal and Corporation Health Committees, representatives of Service Associations, representatives from Factories and other institutions and prominent public men at the District level. The District Collector was the Chairman.

The Committees were in overall charge and were responsible for promoting the targeted number of persons for the camp from their respective jurisdictions and each committee formed sub-committees for different aspects of work as publicity, service, transport, accommodation, camp arrangements, food, remuneration, etc. These committees were the focal points of the broadbased public participation on which the success of the drive depended.

Division of Work and Responsibilities

Responsibility for managing the various facets of the camp and the supporting promotional drive was clearly defined and delineated in an elaborate circular order by the District Collector. This circular had job descriptions with clear outlines of what each functionary was expected to do

and gave detailed guide-line instructions to all concerned with the programme. There were also separate circulars of the District Collector for the organisation of the intensive promotional work in selected pockets of population concentrations and for the deployment and maximum utilisation of vehicles. These circular instructions by the Collector which covered the entire gamut of organisation and management of the camp and their enforcement by him were instrumental in ensuring that the cumbersome machinery of officials of Family Planning and other Governmental departments and the army of non-officials worked as one single team in a singularly efficient and goal-directed community effort.

Scheduling of Areas for Participation in the Camp

Each day at the one month long main camp at Ernakulam and the week long sub camp at Thodupuzha was specifically earmarked for two or three *Panchayats* or equivalent area of the Municipalities/Cochin Corporation in this District. This was for the convenience of organisation and concentrated effort at each local area with specific days in mind for participation in the camp. This technique enabled pin-pointed concentration of the entire organisation and full resources of the drive in one limited area on the day before the appointed day at the camp for that area. It also facilitated groups of people from each *Panchayat* gathering at a manageable number of points on the allotted days, their being transported together to the camp and taken back the same day after the operation, thereby preventing confusion and enabling orderly running of the camp. There was of course no restraint on any person from any area participating in the camp on any day he wished but the general scheduling helped in ensuring at least a minimum number of people every day at the camp.

Publicity and Field Work

Extensive publicity and rigorous field work was organised in support of the camp by the District Family Planning Bureau under the guidance of the Collector. Public meetings were held in every local self-government area, *viz.*, in the 101 *Panchayats*, the 4 Municipalities and the Cochin Corporation of the District. The intensive publicity and educational activities were started two weeks before the camp and built up to a high pitch the time the camp opened. The publicity at the Block level was through public meetings, group talks, etc. The District Collector personally attended the organisational and publicity meetings at the Block Headquarters to elicit broad-based support for the programme. During this period frequent press releases were issued at the District level, appealing for popular participation in the programme. All-India Radio Stations in Kerala cooperated with frequent Radio announcements. The rural areas were flooded with family planning propaganda through street corner meetings, mike announcements, wall posters, notices, banners, slides at local theatres, variety entertainments and

cultural performances on family planning with specific reference to the proposed camp at Ernakulam. Supplements were issued on the camp in newspapers during the duration of the camp. The Family Planning District Mass and Information Officer, the District Information Officer and the Officer-in-charge of the Press Information Bureau constituted the Publicity Coordination Committee in charge of all Publicity for the drive. The Field Publicity Units, the Health Education Units and Film Units of the District Family Planning Bureau were used for publicity in a concentrated manner.

The progress of the field work in each *Panchayat* and Block area in terms of the number of persons who had registered their names for the camp was personally watched and critically reviewed by the District Collector for the two weeks preceding the camp through a system of progress reports. Wherever the field work was considered not upto the mark, the deficiency was corrected by suitable organisational changes and diversion of resources and personnel. The weak links in the campaign were strengthened by personal visits by the District Collector and the District Family Planning Medical Officer and their taking suitable corrective and follow-up action. The field work and publicity, reminiscent of a high powered election campaign, reached a crescendo two days prior to the inauguration of the camp.

At this stage, the publicity units in the field were grouped together and thereafter were deputed each day to the *Panchayats* (3 *Panchayats* or Municipalities or Corporation as the case may be) earmarked for the subsequent day. In the 24 hours preceding the scheduled day, the entire propaganda machinery in the District was concentrated in the particular area. The localised area was saturated with publicity and each *Panchayat* was drawn, as if through a fine sieve, through this concentrated and massive propaganda so that no rural family could miss the message of family planning. House to house campaigns and squad work by team of Family Planning Educators and selfless public workers in each *Panchayat* helped break the resistance to Family Planning and motivate large numbers of people in each *Panchayat* to participate in the camp on the allotted days. In this squad work and promotional efforts, the services of persons in each *Panchayat* commanding the respect of the rural population were extensively used. Leaders of the village community such as local medical practitioners, village Revenue Officials, *Panchayat* Officials, teachers of local schools, women's organisations and prominent village elders joined in the campaign in each *Panchayat* on the personal request and appeal by the District Collector soliciting their cooperation. The dedicated work by these leaders in the squads supplemented the technical competence of Family Planning field workers and made it possible for the group to delve deeply into the psychological barriers responsible for the indifference or opposition of some of the villagers to the idea of Family Planning. Each prospective promotee had personal and complicated reasons for his attitude on Family Planning and

this type of field work organisation ensured the personalised attention which was necessary to take him to a decision-making level. In addition to the house to house campaign, large scale public meetings were arranged on the pre-operation day in each *Panchayat* and these meetings were addressed by local leaders and, wherever possible, by the Members of the Legislative Assembly from the area. Persons who had already undergone the vasectomy operation were also encouraged to speak. The next day after despatching the persons from these *Panchayats* to the camp as per schedule the publicity machinery and the army of personnel moved on to the next group of villages from which persons were to be promoted for the subsequent day. It may thus been seen that the entire District was covered by the most intensive field work and propaganda in the preparatory period for the camp and during the conduct of the one-month long Family Planning Festival. The organisation of publicity and field work was such as to make the promotional effort for the camp a great community effort and a mass movement in support of the Family Planning Programme.

Special Field Work in Selected Pockets

In addition to the intensive and concentrated field work in each *Panchayat*, Municipality and Corporation area, hundreds of pockets of population concentrations were identified and selected by the Collector for special localised promotional effort. These consisted of Harijan, Fishermen and other colonies, slums, factories, special labour concentrations like the Cochin Dock Labour Board, Estate Labour Settlements and Special institutions like the Naval Base, Cochin. Special teams of Family Planning Educators, doctors, officers and public men were entrusted with the task of completely covering these selected pockets with house-to-house campaigns and squad work, mobilising the residents in those pockets and promoting and making them participate in the camp as a group from each of these specified areas. The concentration of resources and determined localised campaign in these selected areas were to bring rich dividends by way of large contingents of promotees from these pockets participating in the camp and boosting up the numbers of persons obtained through the general *Panchayat*/ Municipality/Corporation-wise promotional efforts.

Camp Arrangements

The Town Hall and premises were attractively decorated and adorned with illuminative publicity. Inside the expansive auditorium of the Town Hall, 40 booths with operation tables and accessories were set up. Arrangements were also made for reception, registration, enquiry, pre-and post-operative waiting rooms, preparation, free medical check-up and non-service activities like cash disbursements, control room, canteen, etc. All these sections and stages, medical and non-medical, were arranged within the

Town Hall and its compound in a well-planned lay out, with an eye for minute detail and concern for the amenities of the acceptors. This ensured the smooth flow of persons through the various steps in an uninterrupted and orderly manner. The entire process from the registration to the final departure of a patient took only an hour. Because of this, on the average 500 persons a day could be tackled (on certain days the figure was to go up to 1000 a day) without any confusion or inconvenience to either the acceptors or the staff at the camp.

Staff Deployment

In addition to the staff of the District Family Planning Bureau and the staff of the Family Planning Department in the field, about 30 medical officers and equivalent number of nurses and nursing attendants, the required number of ministerial staff, pharmacists, drivers, attenders, peons and barbers were stationed at the camp during the drive. The staff deployment was arranged in an efficient manner keeping only the required number of medical staff at the camp, depending on the registration of the intending vasectomy patients on each day at the camp. Medical officers and nurses in the various hospitals in the District were, however, in readiness to take up duty at the camp, as and when summoned at short notice in order to tackle the increased number of patients in the camp on any particular day. Thus maximum economy in staff costs and minimum dislocation in the normal working of the hospitals were achieved. The average number of vasectomies per doctor conducted per day was to be about 20 which is the optimum number from the point of view of adequate care and safety in the actual conduct of the surgeries.

Control Room

A control room at the camp presided over by the District Family Planning Medical Officer was the nerve centre and focal point of the organisation and conduct of the camp. This control room maintained continuous liaison with similar control rooms established at each Block Development office in the field. This arrangement facilitated very important tasks of supervision and coordination and made possible immediate action to deal with unexpected developments. Strict control was exercised on the spot by senior staff and decisions were not left to junior assistants for implementation. A Deputy Collector and a skeleton staff from the Collectorate also functioned in the control room of the camp for effective co-ordination and organisation of the massive field work and smooth functioning of the various arrangements at the camp site.

Incentives for Acceptors and for Promoters

A higher level of incentives was made available to each individual, undergoing the vasectomy operation by supplementing the normal incentives with a week's free ration ordered by the Government of Kerala and gifts

raised by public contribution. These incentives helped in no small measure in promoting large numbers of persons, especially persons from the lower economic strata, for participation in the camp and in achieving the ambitious target set for the camp.

Incentives for Organisers of the Camp

Suitable incentives in the form of monetary and other awards were announced by the District Collector before the beginning of the drive. They included special merit certificates on behalf of Government for officials and non-officials performing outstanding service beyond the line of duty in connection with this intensive drive, special monetary awards for field workers for maximum promotional effort, for doctors performing the maximum number of operations, for institutions and for *Panchayats* sending the maximum number of persons to the camp, etc. In each category of officials and non-officials connected with the organisation and conduct of the camp, the best persons in terms of meritorious services rendered were to be recognised and rewarded.

Quality Control

The quality of persons who were sterilised at the camp was kept at a high level by concentrating the motivational effort on the eligible couples during the promotional drive and through screening at the camp site. The individualised promotional effort was on the basis of comprehensive lists of eligible couples already available with the Family Planning staff of the respective areas and this ensured to a large extent that the acceptors were in the eligible category. All the persons who came to the camp were registered in the booths set apart for each local area at the camp site. But only such of the registered persons as were interviewed, screened and passed as physically eligible for sterilization at the pre-operative clinic at the camp manned by Medical Officers and other paramedical staff, were allowed to undergo the operation.

Follow-up Arrangements

Immediately after the operation, the sterilised persons were given injections and antibiotics for use for one week. They were also given printed leaflets containing instructions for post-operative care up to 3 months including cleanliness of the operated and surrounding area, compulsory use of condom for 3 months and semen examination after 3 months. These instructions were read out and explained to them by the Family Planning staff at the camp site, while they were resting after the operation. The sterilised persons were dropped back at their door steps in vehicles avoiding the necessity of walking long distances. Those who were employed in Government, commercial and quasi-commercial and industrial concerns were given special leave with pay for 6 days for rest. The others were advised

to take rest for a few days and do only light work for 10 days following the operation.

The persons who underwent sterilization in the camp had all been suggested by the members of the *Panchayat* level committees and all the persons were known to the Committees and the local staff of the Family Planning Department. The acceptors were to be contacted and their welfare enquired into by the local committee members including Family Planning Staff within 3 days of the operation and once again within 7 days. They were then to be seen by the committee members once in a week for one month and, thereafter, once a month for 2 years. After 3 months, the acceptors were encouraged to get their semen microscopically examined in the nearest health institution and special arrangements were made for the purpose. Whenever any complication was detected or reported, immediate first aid was to be given according to the nature of the complication and hospitalisation resorted to, wherever necessary. The medical officers and Family Planning field staff were to visit the non-hospitalised cases at their residences and render free medical assistance. In hospitalised cases, special attention was to be given to the patients by the medical and nursing staff to effect speedy recovery and the details of the cases were to be reported to the District Family Planning Officer for ensuring continued follow-up after the patient was discharged.

Exhibitions on Family Planning

An audio visual exhibition on Family Planning was organised at the Town Hall to coincide with the one month long vasectomy camp. The exhibition served as an added incentive, motivation and encouragement to the general public to understand and realise the importance of the Family Planning programme.

Public Function at the Camp Site

Suitable public functions were arranged at the camp site to mark its inauguration and conclusion and also at intervals when the camp was in progress.

Camp Publicity

The Town Hall, Ernakulam resembled, more than anything else a centre of popular festivity. During the month long "*YAJNA*", the gaily decorated Hall and its precincts were alive with a constant flux of people, arriving from the various parts of the District, the temporary stalls and the long queues, doctors, nurses and officials going about busily with their jobs, the public address system rending the air with directions and messages, Government and private requisitioned vehicles going in and out of the compounds, the busy control room, the entrance and the crowded hall and after dusk, big crowds rushing into the venue to enjoy the entertainment

programmes. Throughout the length and breadth of the District, the publicity campaign was given a realistic touch by the sight of Government and requisitioned vehicles criss-crossing the district with their loads of persons going to and from the camp. A crowning touch was given by an illuminated sign board displayed prominently in front of the Town Hall on which was displayed the up-to-date figures of the total number of operations performed at the camp. This was indeed a regular—"score-board" and this board and the number on it was the focus of interest to every person passing the Town Hall, which is in the centre of the city of Cochin and on the National Highway.

The highlights of the camp and the daily number of vasectomies conducted were given extensive publicity through the media of newspapers, local stations of the All-India Radio and also by mike announcements and by notices along with the promotional effort in the field. The effectiveness of the publicity organisation covering the camp not only contributed to the success of the camp but also *inter alia,* projected the message of Family Planning to the people of Kerala with a renewed sense of urgency and importance.

Achievement of The First Camp

(November-December 1970)

Though an average number of 500 persons was targeted for the camp each day at the planning stage itself, it was expected that the number of persons coming forward for undergoing the operation in this camp in the initial stages will only be modest. But the District Collector expected the multiplier effect of the propaganda and the words of satisfaction and praise for the camp passed round by the first batches of patients to boost the daily participation progressively as the camp got on the way. The daily participation was expected to increase linearly from 100 persons on the first day to 850 persons on the last day, thereby achieving a total of 15,000 persons in a month of 31 days. This was the theoretical premise and projection around which the propaganda and promotional drive for the camp was organised. This prediction was fulfilled in practice with a surprising degree of accuracy.

In the month-long intensive drive in Ernakulam District from 20th November to 20th December, the number of vasectomies were conducted are given in Table 1.

The achievement of 15,005 vasectomies in this month-long intensive drive can be compared to the targets and achievements in this field as follows:

(*a*) The achievement for *month* in this district is $1\frac{1}{2}$ times the maximum achievement in any *year* in any district in Kerala.

(*b*) The number of 13,891 vasectomies conducted at Ernakulam Town Hall itself and the total number of 15,005 vasectomies conducted in the

month exceeded the yearly target of 13794 for 1970-71 for Ernakulam District approved by the Government of Kerala.

TABLE 1

At Ernakulam Town Hall (From November 20th to December 20th).	13,891
At Thodupuzha Town Hall (From December 13th to December 19th)	1,056
In various Public Health Centres and Government Hospitals in this District (for persons who could not come to Ernakulam and for persons referred to Govt. Hospitals by the camp authorities for treatment before the operation.	58
Total	15,005

(*c*) The achievement is 5 times the maximum number of sterilizations conducted in any district in any one month in India (said to be roughly 3000 in a month accomplished in one of the Districts of Andhra Pradesh—this previous record is unconfirmed), thereby setting up a truly creditable All-India record in this field.

(*d*) The number of 13,891 vasectomies conducted at Ernakulam Town Hall is the maximum number performed in any single camp so far organised in India.

(*e*) The 1083 number of vasectomies conducted at Ernakulam Town Hall on 19th November is an All-India Record by itself for the total number of sterilizations on any particular day in any district or in any single camp.

(*f*) The achievement of 15,005 sterilizations at the camp is 8.7 per cent or slightly above 1/12 th of the total number of eligible couples (1,77,350) in the district who could be theoretically sterilised (B and C groups—couples with one or two children and couples with 3 or more children respectively) at the beginning of the camp. In the camp, 5.6 per cent of the eligible couples in the B group and 9.9 per cent of the eligible couples in the C group were sterilised.

It is also noteworthy that more than one-third the total cost of the camp was met by public contribution and this illustrates the extent to which public participation was achieved in the conduct of the camp. The camp was most productive in terms of financial results in so far as substantially low costs to Government and high benefits to acceptors were achieved by the massive and efficient organisation of the camp and its supporting field endeavour and the economies resulting from it.

Some Highlights of the First Camp
(November-December 1970)

Public Cooperation

The camp was organised with the active participation of the local leadership of 101 *Panchayats*, 4 Municipalities and the Cochin Corporation in this District. *Panchayat* Presidents and members, Municipal Chairmen and Councillors and Corporation Mayor and Councillors and hundreds of public men cooperated with the Government Departments at the stages of publicity, promotion and actual conduct of the camp. The extent to which *Panchayat* institutions and public leaders at the District, Block and Village levels got involved in the programme was truly unprecedented. The local bodies entered into a spirit of healthy competition vying with one another to promote and send as many persons as possible for undergoing the operation at the camp. The Committees at the local self-government level constituted for the purpose of the camp worked with whole-hearted dedication for its success. Thus the criticism that the Family Planning programme has been a purely governmental programme has been completely overcome as far as this district is concerned. In this camp and programme, the non-official agencies took the leading part not in theory but in practice. And the success of the camp reinforces the general finding throughout the country that the best family planning leaders are those with traditional leadership roles in society.

Cooperation of Industries and Business Sector and Private Organisations

The large outlay of non-governmental expenditure for the camp was made possible through financial assistance from almost all the noted industrial and business houses in Cochin. The substantial benefits and services rendered to the vasectomy acceptors which was a special feature of this camp would not have been possible without the unstinted support extended to the District Collector by these non-governmental organisations and agencies.

Inter-Departmental Cooperation

Another notable feature of the camp was that all the departments of Government in the district assisted the Family Planning Department in this drive. This was made possible since the District Collector who has an overall control over all the departments was also the Chief Organiser of this unprecedented family planning effort. Officers of the Revenue Department down to the Village Officer, officers of the Education Department down to the Primary School Teacher, officers of the Community Development Department down to the *Gramsevaks* were working in the field aiding the promotional effort for the camp. Other departments such

as Sales Tax, Motor Vehicles, Harijan Welfare, Industries, Civil Supplies etc., helped in whatever way possible for organising the various aspects of the camp. The coordinated working of the different Government Departments resulted in an integrated effort using the whole force of the Government machinery and this was also responsible for the success of the camp. The camp was in fact a model of efficient mobilisation of both official and non-official agencies under the leadership of the District administrative head; who was able to get down to brass-tacks at any level whatsoever, to remove the bottlenecks which developed from time to time and keep the elaborate machinery on the move.

Use of the Extension Machinery of the Community Development and the Intensive Agricultural Area Programmes

Another pertinent fact emerging from the experience of the camp is that the Community Development Village level workers are in an excellent position to promote the family planning programme at the village level and that the programme missed a vital source of strength and power by so far making only comparatively little use of the Community Development Organization. It may be noted that Ernakulam is an Intensive Agricultural Area Programme (I.A.A.P.) District with an elaborate network of agricultural extension field workers and though the services and supplies needed for the agricultural and the Family Planning Programmes differ widely, the same crucial central thread of extension education runs through both the programmes. The field organization of the Ernakulam Family Planning Drive points to the fact that inter-linkages of the two programmes in extension education areas such as I.A.A.P. Districts offer challenging possibilities to the Family Planning programme in the country.

Participation of Rural Population and Economically Weak Strata of Society

One of the criticisms against the family planning programme so far has been that the family planning message has not seeped down to the lowest economic strata of society, especially the illiterate and uneducated masses of the rural areas. The statistics of participation in the camp show that the vast majority of the promotees at the camp came from these strata from the rural areas of the District. The camp succeeded in ample measure in changing the attitude of rural population groups in the District in favour of the Family Planning Programme. The Family planning effort through this camp thus reached truly and effectively the common mass of the people in the District.

Satisfactory Nature of Technical Arrangements

Special precautions were taken at the camp to minimise infection and other complications and maintain absolute asepsis. Instruments were sterilised inside the Sterilisation Theatre and linen autoclaved, in the outside

hospitals including private hospitals. Antibiotic injections were administered as an additional preventive measure against infection. The surroundings were kept absolutely clean and hygienic with the help of the Health staff of the Cochin Corporation. As a result of these precautions, complications consequent on the operation were few. Arrangements had also been made for thorough follow-up and prompt treatment of reported complications both in the camp as well as in the neighbouring Government Hospitals. In the camp only one in 30 of those operated had minor complications and only one in 250 had complications requiring hospitalisation. All the hospitalized persons were also completely cured. These statistics are a reflection of the very high standard of technical arrangements at the camp, the skill and care with which the operations were conducted by the team of doctors and the satisfactory nature of after-care during this drive.

Overcoming Traditional and Religious Barriers

Ideological, religious, traditional and other obstructive forces did not hold sway against the conduct or success of this camp. All political parties and their members, Members of Legislative Assembly and public leaders at large supported this endeavour. Even those who are normally stoutly opposed to the Family Planning Programme helped the camp by remaining silent and not overtly opposing the promotional effort.

The religion-wise break up of the number of persons vasectomised in the camp also presents a revealing picture. There is an overall increase in the proportion of sterilizations at the camp in respect of religious denominations such as Christians and Muslims who were lagging behind in participation in the Family Planning Programme. This fact itself is an indication that all sections of the public have felt the necessity of Family Welfare Planning, thanks to the effective propaganda of the Ernakulam Intensive drive. The camp has thus shown that through concentrated and massive effort, the normal resistances to family planning methods can be broken and overcome and that participation on the programme of the large masses of people in the country irrespective of community or other barrier can be achieved.

This points also to the fact that it will be faulty to presume blandly that certain religious groups are antifamily planning, and that it will be a grievous error, if based on this presumption the programmes of Family Planning Education and Motivation erroneously do not cover such groups. It would seem that wherever programmes have covered all religious groups with the same intensity, the response has been good; and the results of the Ernakulam camp only reinforce this conclusion.

Dispelling Cloud of Secrecy, Embarrassment and Wrong Notions Surrounding Male Sterilization

The camp succeeded in overcoming the apprehensions of prospective acceptors resulting from wrong notions and fears surrounding the vasectomy

operation such as loss of potency and health, by effective technical advice, information and propaganda. The camp succeeded also in large measure in overcoming the resistance to adoption of vasectomy as a family planning method, resulting from a feeling of embarrassment of the male, born out of fear of others knowing of the operation, and, in general, from prudery regarding a subject relating to sex and reproduction. The Town Hall at the very centre of the Town was selected as the venue for the camp and the camp was organised in full public gaze with the aim of breaking down this barrier. Though for the first few days this resistance could be felt, it was progressively overcome. People in large numbers came to the Town Hall with the same spirit and absence of embarrassment as they would have come for inoculation against cholera or smallpox. The prospective acceptors could have been seen standing in queue in front of various counters or waiting in front of the operation room as casually and without any self-consciousness as if they were at a cinema ticket counter. The large numbers of people who were registering at the Town Hall for the operation helped yet undecided persons to decide in favour of undergoing the operation. One of the highlights of the camp was a *jatha* organised at the instance of the District Collector by the Block Development Officer, Pampakuda who promoted and brought 400 persons to Ernakulam for participation at the camp. These persons went in a *jatha* through Ernakulam Town announcing that they have came for the operation and shouting slogans in favour of family planning before presenting themselves for registration at the camp. Their inspiring and powerful slogan in Malayalam, translated into English, was

"Hear the voice of the Indian Masses
Who Sweat and toil on this sacred land
Hear this patriotic clarion Call
Two (parents) we are and two (children)
(only) for us !"

This demonstration would probably have been the first public demonstration in India by the common people in support of the Family Planning Programme. Similar *jathas* were organised in the rural areas to elicit support for the programme. Through such demonstrations and the multifarious methods of effective propaganda and field work, the Family Planning Programme of Government in Ernakulam District was organised and built up into a popular movement.

Characteristics of Sterilized Persons

A study of the demographic and socio-economic characteristics of persons sterilized at the November-December Camp at Ernakulam has been conducted by the National Institute of Family Planning (CPI), New Delhi. This preliminary study has been obtained by drawing and tabulating a 20 per cent sample of the case cards. The Institute is doing a more detailed evaluation of the camp, to be brought out shortly.

The study shows that (*a*) 54 per cent of the camp acceptors were below 40 years of age and hence in the highly fertile age group as against 63 per cent in the regular district programme and 60 per cent in Kerala State. The mean age of camp acceptors was 38.9 years and only slightly higher than the average of 38.0 years for the regular district programme and 38.1 for the State. Percentage acceptance in the 20-29 years age group was higher in the camp than normally in the district or State.

(*b*) 38 per cent of the wives of persons vasectomised at the camp were below the age of 30 years, and hence in the highly fertile age group, as against 41 per cent in the district and 31 per cent in the State. The mean age of the wives of camp acceptors, 32.2 years, compares favourably with the average of 33.7 years for the State, but it is marginally higher than the 31.3 years for the regular district programme.

(*c*) 42 per cent of the camp acceptors had three or fewer children as compared with 39 per cent for the district and State. Overall, however, these distributions are also fairly similar, demonstrating the quality of the camp performance to be as good as that of the district and State.

(*d*) the sterilization of 15,005 men, whose wives were on average 32 years old and 62 per cent of whom had four or fewer children, is likely to have a substantial effect on averting future births in Ernakulam District.

(*e*) the acceptance factors for Hindus, Christians and Muslims were 1.10, 0.91, and 0.74 respectively in the camp, as against 1.29, 0.83 and 0.43 respectively in the district and 1.22, 0.85 and 0.42 respectively in the State. This improvement in response from minority groups can probably be attributed to the intensive promotional campaign accompanying the camp and the larger than usual incentives, and is one of the successful features of the camp.

(*f*) the bulk of the acceptors, almost 80 per cent are from the lowest income groups who are the neediest in terms of family planning services.

(*g*) over 70 per cent of the camp acceptors were from the lower-socio-economic strata, with either no formal education or only primary school education.

On Incentives and the Camp Approach

There has been considerable discussion of the merits and demerits of incentives *vis-a-vis* the Family Planning Programme in India, particularly on the basis of the experience of Tamil Nadu and Maharashtra, where the general level of payments to clients, motivators and medical personnel has been raised significantly above the national pattern. It seems that the proponents of increased incentives have argued that they ensure participation of promoters of a socio-economic status comparable to that of the prospective acceptors of family planning and who can therefore more

easily communicate with them than extension educators, health educators and social workers. Critics of higher incentives on the other hand have argued that for lasting results, reliance needs to be placed on appropriately educated and trained personnel. There is probably truth in both these arguments. But the Ernakulam drive was not built around the higher level of incentives alone but on a broad-based and intense educational and promotional effort combining the training and knowledge of Family Planning workers with the influence of opinion leaders and public men on the rural populace in each village.

Incentive is a subject about which there seems to be an extreme sensitivity in the Family Planning Programme circles in the country. While agreeing that further increase in monetary incentives would induce improved programme performance, the critics of high incentives argue that the expense of this type of policy mounts rapidly and that, after some time, the rate of acceptance will drop off considerably. The recent experience of Tamil Nadu and Maharashtra is cited in support of this argument. The Central Family Planning was expressing this sentiment when it passed a resolution in 1968 recommending "that as adequate Family Planning services become increasingly available for being provided at the door-steps of the individuals, and as there is more and more public response, the existing compensation amounts should be gradually reduced and ultimately withdrawn." Before implementing the change proposed in this resolution, we have to evaluate carefully the costs and returns from the compensation/incentives approach as well as examine the question whether the stage has been reached in the programme for reducing the role of incentives.

Nobody denies the self-evident fact that any large scale family planning programme has to take into consideration both the short-term and the long-term objectives and that measures that are undertaken in order to reduce the birth rate "as quickly as possible" have to be chosen carefully so as not to create adverse long-term effects on the gradual acceptance and practice of family planning as a matter of individual choice. This voluntary nature of the programme is the acknowledged policy of India. Any by-product of "crash" programme measures, which may adversely affect the sustained practice of family planning in the long-term perspective should be guarded against. But while endeavouring to achieve the long and short-term programme goals, the practical realities of the Indian rural situation have to be taken into account. In the field of population control, India needs more actionless sensitivity and abstract considerations. We cannot escape from the fact that after all the educational effort and propaganda the national average performance per month by an IUCD unit was only 10 cases and by a sterilization unit, 17. We must realise that the question of population control cannot be settled in India by stating the case for it and it would be erroneous to presume that simply by opening a Family Planning Centre, India's rural folk will start flocking to it. It needs to be clearly understood that the

idea of family planning needs hard selling among the rural masses of India who live in abject poverty. We are also precluded from taking certain steps which might hasten the progress of Family Planning as they are against the democratic conscience of our country. This makes the task all the more difficult and challenging. In these circumstances, if incentives are an effective aid to promotion they have to be employed till the programme gathers enough momentum and reaches a stage at which the prop of incentives is no more needed to support it. It does not also seem correct to say that incentives will make the programme costlier. By intensive use of the group approach and massive organisation, the cost of additional incentives can be more than compensated by the savings in the per acceptor expenditure on the education, propaganda and the overheads of the programme. The economics of the camp at Ernakulam is ample proof of this premise.

When we think of measures which must be adopted urgently, to contribute to a solution of our population problem, we have to accept the fact that the community birth-rate in a given population, rural or urban, cannot be reduced significantly and expeditiously by an educational programme alone. The propaganda-cum-camp approach supported by incentives adopted in this experiment was not in conflict with the education-cum-clinic approach of the normal programme. Nor is it in conflict with the fundamental validity of a planned education programme; on the other hand, the camp with its supporting intensive propaganda drive and additional incentives was founded on an effective educational programme and was an effective vehicle, medium and platform for that programme. Any realistic assessment of the degree of knowledge gained by a rural group from the normal teaching programmes and retained by it afterwards will reveal that the educational programme by itself, by and large, only skims the surface and at best creates only an awareness of the need for family limitation. The family planning programme in India certainly has created this general awareness in the large majority of the population. It is said that about 80 per cent of the people in urban areas and between 60 and 70 per cent in the rural areas in India are aware of Family Planning.

But awareness of Family Planning though desirable, is not sufficient. It is a lower state of mind than the state of intense desire required if a villager is to apply the principle to his own family. This intense desire must turn to an urge to act culminating in his actually taking a decision to choose a Family Planning method and acting on it. We must remember that we are dealing with fatalistic attitudes in existence for generations and that in rural India "acceptance" is not synonymous with practice—the lag between them being due to psychological, social and logistic reasons. There is a significant gap between possession of knowledge about Family Planning, and that too mostly inaccurate and inadequate knowledge, and the actual practice of a Family Planning method. The camp at Ernakulam succeeded in reducing this gap between awareness and physical results to the

space of a few days by the nature of its organisation and by the intensive and concentrated nature of the educational propaganda and motivational drive supporting it. Thus the slowness with which rural populations take to family planning, the greatest barrier to the final attainment of programme goals was overcome during the Ernakulam drive.

It can also be justifiably claimed that the camp itself has strengthened the educational programme. The experience of the acceptors who underwent the operation will be of educative value to the rural groups to which they return insofar as the other villagers in the groups realise the benefits, short-term and long-term, derived by the acceptors. The crystallised wisdom of centuries to which the Indian peasant is the heir is a wisdom built on practical experience. He will, therefore, react more positively to the realities and changes in his environment rather than to mere dissemination of information. The multiplier effect of this communication through the 15,000 acceptors at the camp is bound to give a substantial boost to the entire programme not only in Ernakulam District but the whole of Kerala State.

Thus the incentive and the educational approaches are not necessarily in conflict with each other and should be viewed as complementary factors in the strategy for realising programme goals. A crash programme for family planning will have to be implemented on a war-footing and this can be done by a series of thrusts through the incentive approach in conjunction with a sustained educational programme.

The apprehension occasionally voiced that the periodic intensive drive approach depresses performance in the non-intensive periods is also not well founded. The maintenance of a high tempo for the programme throughout the year is a function of the ability and drive of those who control and direct the programme. It may also be mentioned that the intensive approach at selected intervals by concentration of resources is already an accepted policy of the Government of India in the Family Planning Programme. In fact, the Family Planning achievements rise high only in intensive Fortnight/Month periods. The following Table shows comparative achievements of the intensive periods with those of the total programme in Kerala. The achievement per month during intensive drives in Kerala is thus 5.7 times the normal for sterilisation and 2.5 times the normal for IUCD insertions. This is due to the intensive and combined effort of the whole Family Planning Staff and also due to the cooperation of local bodies, other departments and voluntary agencies during the intensive periods. The Ernakulam Camp was only an extension of this intensive approach with the difference that a District level camp was conducted with additional incentives and that the intensity of the motivational drive was of a much higher order.

TABLE

FIGURES AS ON 30TH JUNE, 1970

	Achievement during past 11 F.P. fortnights/ months (Total of $6\frac{1}{2}$ months)	Progressive total from inception of programme	Achievement/ month Intensive period	Total progress	Ratio
Sterilisation	75,352	3,64,763 (Fifteen years started in 1955)	11,593	2,026	5.7
IUCD	51,270	1,93,006 (Five years started in 1968)	7,887	3,217	2.5

The camp and clinic approaches in the family planning programme are also not in conflict with each other but complementary. An effective programme of motivation should overcome all the impeding factors for acceptance by the masses of the message to be communicated. The mass psychology is such that these barriers are more easily crossed when conditions have been created for group acceptance. The group approach also enables generation of a positive attitude towards the population problem on the basis of a kind of psychological identification of the individual with the people, the nation conceived of as a collective unit living down the generations. The intensity of this positive response depends on the degree of psychological identification of the part of the citizen with his nation. In the group approach, individual action receives community approval and the social climate stimulates people to change their personal behaviour. The creation of these conditions was one of the reasons for the success of the Ernakulam camp.

It would seem, therefore, that for the initial stages of motivational campaigns, a group approach is the best strategy. Group approach possesses other tactical advantages,

(*i*) With the given resources, large population groups can be covered.

(*ii*) According to the rules of statistical probabilities from the simple fact that motivational campaign is directed to larger sections of the target groups, the absolute numbers of those actually becoming motivated would be larger. For maximising the results from all inputs of efforts, resources, etc., the individual approach is best undertaken when the proper climate has already been developed through the group approach. This is planning

the programme in an area where the camp and the clinic or the group and the individualist approaches can be advantageously combined in an optimum mix and this is proposed to be done in the future programme for Family Planning in this District.

Future Programme of the "Yajna"

The November-December 1970 massive vasectomy camp at the district level is only the first step in the concerted effort planned in Ernakulam District to make this the foremost district in India, in the implementation of the Intensive Family Planning district Programme. More camps are being organised at the district and Block level on the model of the November-December 1970 camp and they will be organised in a similar manner with the help of non-official agencies and the public. Along with these district level and Block level massive camps for vasectomy, tubectomy for women, large scale IUCD insertions, use of prophylactics and other family planning methods will be popularised on a massive scale throughout the length and breadth of the district.

In addition to rectifying the defects and deficiencies of the November-December camp as seen by experience, the future camps will be organised on a broader canvas from the point of view of basic Family Planning strategy. The camps will have a cafeteria approach, *i.e.*, in addition to the sterilisation, all eligible couples will have the choice of any suitable Family Planning method. The camp will also be a venue for imparting knowledge about the Family Planning methods. All available methods will be explained to prospective acceptors in detail by experts and they will be given a chance to select the method most suitable and feasible for them.

The camps will have additional facilities and programmes like a medical exhibition, free medical check up for acceptors and their families, cultural programmes, baby clinics, P.H. programmes and Health Education and presentation of ideal families (Planning and unplanned families). The camp will thus be organised as total Family planning Festivals, with the message of total health care and protective measures with reference to the welfare of the community. The concept of the camp will be Family Planning in terms of maternal and child health plus total medical care.

The camps will have a built-in mechanism for concurrent research and experimentation with independent research teams in charge. The urgent need for thorough and continuous evaluation of the present sterilization programme and for adequate arrangements for a systematic feedback of findings need not be over-emphasized. Such evaluation should centre not only upon clinical facilities and sterilization methods, but also upon the different approaches to attract couples to accept sterilization. The motivational and educational aspects of sterilization need to be stressed.

Studies are needed regarding the psychosomatic and possible long-term psycho-sexual effects upon acceptors of sterilization. Such studies will yield a more complete picture of the role of sterilization as a population control method in the long term. There is need more carefully to assess the demographic significance of sterilization. Well-designed studies are needed on the characteristics of accepting couples, particularly with respect to recent pregnancy history, parity and age of wife and socio-economic status. Comparative cost benefit studies of sterilization camps and alternatives such as addition of beds to hospitals and improvement of facilities at the P.H. Centres can be undertaken. The future progamme in this district will be designed to cater to these vital research needs also. The programme will thus incorporate the three-pronged approach of the Family Planning Programme symbolised by the red-triangle-motivation, service and research.

A special grant from the Government of India will also be requested for the district's future programme as conceived above. Also it should be possible to find more funds for the district's programme, if discretion is given to the State Government to deviate from the sanctioned patterns and to transfer a portion of the funds within the programme to areas and schemes when such diversion is justified by the results accomplished. This flexibility in the allocation of funds is essential for maximum utilization of human and material resources as well as for building up management capability at the State and district levels. It has to be emphasised that the critical points for management improvement in the programme is at the district level, where management of personnel, information, records, material and other resources, will have decisive influence on programme results. The quality of the programme at the block and village levels including maintenance and use of records is affected by the nature of supervision from the district. Therefore, it will be appreciated that decentralisation of authority and devolution of funds to the district level with built-in flexibility and openness to changes is essential to ensure efficient programme implementation.

In view of the success of the Ernakulam experiment, Government of India will also be requested to name Ernakulam an experimental district so that funds set apart for experimental projects in Family Planning are available to a certain extent for the district's action-cum-research oriented programme. The experimental components of the programme can include the role of incentives whether cash or kind; individual or community, immediate or deferred; sliding scale or constant; camp versus clinic approach; community versus Family Planning Bureau approach; different types of promotional compaigns, etc. There is great potential also for controlled experiments on the inputs and various facets of the programme. Experiments in a limited number of districts in this manner would be financially manageable and at the same time would facilitate an assessment of costs and benefits for the whole programme. This will also be in keeping with the

"Intensive Districts" approach to Family Planning of the Government of India as Ernakulam has been named an Intensive Family Planning District and it has also the background of innovative performance and "modernisation proclivity" through extension education resulting from the Intensive Agricultural Area programme. The district will also seek the continued assistance and participation of CARE and other voluntary organisations in the same manner as at the Ernakulam Camp for its future programme. In addition, the assistance, technical and financial, of national and international agencies involved and interested in the Family Planning Programme of the country will be available for the future programme, subject to these agencies agreeing to participate, and the Government of India concurring. The organisers of the Family Planning effort in Ernakulam have no doubt that, through such a broad-based and sustained intensive drive, it will be possible to bring practically all the eligible couples in this district within one method of family limitation or another in a time-bound five year programme.

Conclusion

The Massive Vasectomy Camp in Ernakulam District (November-December 1970) has been acclaimed throughout the State of Kerala and, wherever news of it has reached in the country, as a landmark in the Family Planning Programme of India. The number of fifteen thousand vasectomies conducted in a month in this district during this drive is acknowledged to be a record in this field. The success has been made possible through the cooperation of and coordination among the various departments of Government, local self-government bodies, industries and business sectors, social service organisations and a large number of public men interested in the welfare of our country. Imaginative and effective planning of the drive, massive and concentrated field work and propaganda supporting it, and excellent camp arrangements also contributed to this success.

The second massive camp of the District's Intensive Family Planning campaign is being organised as a gigantic Family Planning Festival at the Town Hall, Ernakulam with a sub camp at Thodupuzha, from 1st July to 31st July 1971. The camp will have excellent technical arrangements and the services of highly qualified doctors. Medical follow-up of all the sterilizations conducted at the camp will be most scientifically and properly organised. This camp will provide the opportunity for a "Cafeteria and Menu Card Method" to needy eligible couples. The tentative target fixed for this festival is 20,000 vasectomies, a large number of tubectomies and IUCD insertions and Nirodh distributions. There will be arrangements at the camp for recanalisation operation for all registered cases, infertility case study for all registered cases, medical check-up for the family members of all who are adopting sterilization in the camp, baby shows, cultural programmes and a Family Planning exhibition.

The promotional effort for this massive camp is being organised in the same fashion as per the first camp but on a more comprehensive scale. 501 popular committees are being formed in the district for concentrated propaganda to spread the Family Planning message to every home in the district and for the intensive promotional effort to persuade the targeted number of families to adopt some family planning method during the festival. These include committees for the Cochin Corporation and its fortysix wards and the four Municipalities and 101 *Panchayats* of the district. Special committees are being formed for squad work in selected pockets of population concentrations such as Fishermen, Harijan and other colonies, slums, large industrial and office establishments, etc., *i.e.*, pockets where large numbers of people live or work together. Professional Associations, Trade Unions, Social Service Organisations and other institutions which control large numbers of people in various avocations are also being requested to form special committees of their own to persuade and promote eligible couples from among their members to participate in the camp.

This camp is thus being organised as a total Family Planning Festival, with the message of total health care and protective measures with reference to the welfare of the community. The physical achievement of this camp promises to be the highest ever obtained by any single family planning effort in the country. The organisers of this intensive campaign wish to carry the programme forward with the hope that their efforts will be a meaningful contribution to the Family Planning Programme of the country.

THE ROLE OF VOLUNTARY AGENCIES IN FAMILY PLANNING

LEELA DAMODARA MENON*

When the accent was given in India on an accelerated programme of industrial and agricultural growth, it was accepted that the size of the family will grow smaller, during the developing decades as in other countries, where, under similar circumstances, a conscious effort was made by the people to have smaller families, to ensure for themselves better standards of living and greater individual happiness. That did not happen. Realising that economic growth has not kept pace with growing numbers, especially after the death rate has been considerably lowered, the Government of India began to launch an all-out campaign for population control, which is unequalled in magnitude. The target has been to reduce the birth rate to twenty-five per thousand. The Government has provided funds, clinics, services, publicity and propaganda. "Small family, Happy family" and "Two are enough" have become well-known slogans. For 547 million people, speaking 11,600 dialects and 240 districts, 2690 towns, and 567,179 villages, a gigantic scheme of 340 District F. P. Bureaus, 5225 rural centres and 31952 sub-centres training centres and the like are envisaged during the fourth plan in continuation of the work already done. 10 million couples of the reproductive age group have to be contacted and motivated. It is only then, that the people will start enjoying better economic facilities. This dream for progress and prosperity will not materialise, if this massive effort is not successful and the present rate of population growth continues.

Voluntary organisations were the first to point out the need for Family Planning in this country. Organisations like the All-India Women's Conference and the Family Planning Association of India took up the propaganda for Family Planning, even when the subject was hush hush and taboo. They bore the first and strongest impact of orthodox antagonism, which, with their sincerity and genuine interest of service to the public, they could withstand successfully.

When the idea became a national policy, the organisational set-up was planned by the Government like a network of blood vessels, to take the message through the length and breadth of the country. But, somehow, the whole scheme has failed to ignite popular enthusiasm to the extent

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required, as the latest census figures point out. It is in this context that it has become necessary to have a rethinking on the vital role of voluntary organisations bringing fresh life to this movement. "The Family Planning Pill" needs more sugar-coating to attract the people.

In a democratic set-up, the size of the family is essentially the problem of the parents, to be solved by them alone, for their own benefit and for the well-being of their children. It is theirs to decide as to the number of children they want to have and the interval between them. This voluntary action is their human right. Who can stimulate this voluntary action ? Voluntary agencies certainly can. They can effectively supplement the Governmental programmes by mobilising public support.

A hard crust of prejudice, traditions and superstitions is still in existence, especially in rural areas, regarding child birth. Though the joint family system is fast disappearing and quickly being replaced by the unitary family, people still find security in number and view large families as a means of social defence. Language, customs, prejudices and special interests are obstacles for proper communication to these groups. It is to break through this tough ground that the voluntary agencies are most useful.

Who are Voluntary Agencies?

There are thousands of voluntary agencies in the country, actively interested and catering to more than one felt need in community. They are established with service motive and are inspired with a zeal to alleviate human hardships. The community considers them as their well-wishers, working for their benefit. They are not bound down by red tapism and procedural delays and have freedom of operation. They have also gained social acceptance by the very fact of their continued existence.

The voluntary agencies are of four categories :

I. Those that are exclusively devoted to Family Planning, like the Family Planning Association of India, Planned Parenthood of India, Population Council and Family Planning Foundation.

II. All welfare organisations at the National, State District and *Panchayat* levels, engaged in social work. They can take up family planning programme also along with their welfare activities. Their number goes to thousands. Among the National Organisations, can be counted, the All-India Women's Conference, the Bharatiya Grameen Mahila Sangh, the Women's Council, the Y.W.C.A., Y.M.C.A. and Rotary and Lions, clubs, etc.

III. *Other groups :* Trade unions, youth organisations, cooperatives, and *Panchayats.*

IV. *Professional Associations* like the Indian Medical Association, Bar Associations, etc.

All these groups have a clientele in the community.

The Role of Voluntary Agencies

1. To bridge the gap between the officials and the public.
2. To educate the public to make Family Planning as much the need of the individual as it is a national need.
3. To break through the wall of superstition and traditions.
4. To remove doubts and soft-pedal the resistance of non-responsive groups.
5. To make available supervisory staff when needed.
6. To utilise propaganda material properly.
7. To act as stockists for contraceptives.
8. To organise clinical service where there is none.
9. To take the services and the message of Family Planning to the door steps of the people especially in backward areas and tribal areas.
10. To make family planning a priority programme among their activities.
11. To conduct Seminars and Camps.
12. To create public opinion on the need of social reforms connected with family planning like raising of the age of marriage, etc.
13. To coordinate the expert services of the officials with that of honorary workers and make it integrated with welfare programmes.
14. To reach the most vulnerable section of society—the women.

The national sample survey has shown that the rate of childbirth is as follows :

Illiterate women	— 6.6 children
Middle school educated	— 5.0 ,,
High School	— 4.6 ,,
College Educated	— 2.03 ,,

It is, therefore, imperative to educate women to change their attitudes quickly as they are the hard core that requires the toughest motivation.

Choice and Nature of Voluntary Agencies

The most important factor is to find out what each agency is capable of doing. In order to know that, important organisations at the National, State, District, Block and *Panchayat* level will have to be tested, examined and a role assigned to each. A national register of voluntary organisations may be started as an urgent step.

While enlisting the cooperation of voluntary agencies, the complex nature of the task should not be overlooked. Technically qualified staff of the Governmental agencies and honorary workers have to cooperate and coordinate their activities.

Difficulties of Voluntary Agencies

The feeling of aloofness and lack of mutual understanding hampers proper integration of the work between official and non-official agencies. A sense of inferiority complex is developed between them which makes them antagonistic to each other.

Unhealthy competition and duplication of activity have persuaded some of the best voluntary organisations to withdraw from the field of Family Planning. Inflexibility of the grant-in-aid pattern and the tardy methods of release of grants create misunderstandings between the official and non-official agencies. Voluntary workers lack training. The voluntary agencies involved in the grant-in-aid programmes are uncertain about the continuation of their work for lack of timely release of the grant funds.

The question often asked is why call them 'voluntary', if they have to depend on full-time grants. If they are receiving grants, why not follow the governmental pattern fully ? It is to be noted here that voluntary organisations have their own burden of existing welfare activities, funds for which are becoming more and more scarce. To call upon them to give their time, energy and influence to promote family planning work as well as meet the additional expenditure and the job of raising part of the funds for specified projects, will be asking too much from them.

Grants-in-aid

An analysis of the grant-in-aid scheme will show that grants for the most part are earmarked for salary of staff and equipment. The administrative charges admissible are very limited and much less than the administrative expenditure of governmental agencies. It would be unfair to add to the financial commitments of struggling welfare organisations for the extra work put on their shoulders for family planning and get them to face financial crisis due to non-release of funds in time.

Whatever funds are released for specified projects to the voluntary organisations should be properly accounted for. Evaluation of work has also to be done.

The Government of India has recognised the need for assisting voluntary agencies who are engaged in Family Planning. A great deal of changes also have been made during the course of recent years to relegate authority to the States for the release of grants in order to simplify the procedure. But it is still very slow.

The pattern is that 25 per cent of the grant sanctioned is released early in the year and another 25 per cent later. The balance of 50 per cent is, however, released only after the audited statements for the year are produced with a utilisation certificate for the full amount due. This is all right on paper. But sometimes a whole year passes by without grants. Less than 5 per cent of the institutions alone are able to keep to this schedule and

that also, because they can divert their own funds. But the majority of organisations find it impossible to go ahead under the present pattern for long.

At present, only 401 Family Planning welfare centres are run by voluntary agencies and those are under heavy strain.

If more voluntary agencies are to be brought into the picture, a review of the grant-in-aid system is necessary. There is need for a more flexible pattern and a practical approach to the grants distribution. Each voluntary agency may first be assessed as regards its abilities, funds being given only according to its capacity for work. But once accepted, taking into account the need of accountability and audit, the flow of assistance should be such as to keep the work unhampered.

A Revolving Fund

It is to be considered, whether a revolving fund could give temporary assistance to struggling institutions, while they await the grants. The loan will be returned when the grants come. This will save temporary stoppage of work due to scarcity of funds.

Voluntary agencies can also be grouped into those working in the urban, the rural and the tribal areas and should have different patterns of assistance.

It should also be remembered that the Family Planning programme is part of a family welfare scheme. The local bodies, *Panchayats*, trade unions, cooperatives, professional associations, industrial labour, and voluntary agencies engaged in Family Planning should get together for mutual consultations from time to time and avoid overlapping of activities. The initiative should be taken by the official agencies. These can make Family Planning a mass movement.

Whenever put to the test, voluntary effort has risen to the occasion. In Gandhigram, in Ernakulam District in Kerala and in several parts of India, big projects have exceeded the targets of its promotors, when the Government and the voluntary agencies have combined their efforts in a friendly and understanding spirit.

The success of the work of the voluntary agencies depends very much on the attitude and earnestness of the Government to get them involved. The time has come to take definite decisions on this issue.

SUMMARY OF PROCEEDINGS OF THE SECOND SEMINAR

V. JAGANNADHAM*

In his welcome address, the Director drew attention to the following salient points which emerged from the First Seminar :

1. The family planning programme has been proceeding in an isolated manner with emphasis on clinical approach. This seems to require modification.

2. It was felt that family planning programme should become part and parcel of a larger scheme of social service and social security scheme, thereby contributing to the total well-being of the family.

3. In the implementation of the programme, there is need for a greater scrutiny of the organisation, manpower, financial resources and technical know-how and their inter-connection.

In his inaugural address, the Union Deputy Minister of Health and Family Planning, Prof. A. K. Kisku, emphasised that consequent upon a reduction in the death-rate and increase in the birth-rate, there is bound to be a high population growth-rate unless the family planning programme succeeds. He also drew attention to demographic imbalance caused by the heavy percentage of children under 15 years of age. He was of the view that "the per capita benefit of national economic development is seriously diluted by a high rate of growth of populatiom". He hoped that the deliberations of the seminar will be fruitful in the field of family planning "which seeks to create fundamental behavioural changes in the society."

During the discussion, there was a fairly wide-spread view that the present "war-footing" approach should be modified in favour of extension education and communication to the families on a person to person basis. There was also some unhappiness over the targets and clinical approach. It was said that the targets were fixed for the revenue staff or for the magistracy who were accustomed to getting things done through fair, foul or other means. These targets were regarded as orders which were to be carried out by any means. This approach was felt to be improper and inadequate for the success of the programme because of its close association with human values, sentiments and preferences.

There was considerable discussion on the uncritical acceptance of

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family planning as a pre-requisite for bringing about economic development. A global view of reduction in numbers as a basis for enhancing per capita income was considered to be neither logical nor convincing. One of the participants pointed out that there was no study to show a negative correlation between babies and savings. It was pointed out that babies do not compete with savings. A view was presented that, instead of emphasising a reduction in numbers, the emphasis should shift towards nutrition, education, social security and family welfare.

The Hon'ble Minister, intervening in the discussion, said that the family planning programme should not be treated as an isolated programme and should be considered as part of the totality of programmes as much as community development, economic development and social development. The Minister was of the opinion that, in the field of family planning, all concerned should organise a vigorous education programme before the organisation plunges into the implementation of family planning targets. In his view, education alone will enable each family to decide for itself. He also expressed the view that in the whole programme of family planning, there has been a lack of coordination between different departments of the Government, the headquarters and the field and between voluntary organisations and the official organisations.

At this stage, the discussion centred round whether the family planning programme should be abandoned or continued. There was a fairly widespread opinion that the programme should continue but a time had come for the programme to develop into a package programme consisting of education for better family life, availability of better nutritious food, more employment opportunities for women for making them economically independent, more social welfare and social security measures for gaining the confidence of the people about the survival of their children, and the maintenance of old people during their old age without too much dependence upon their progeny. Such an approach would mean the abandonment of undue emphasis on target fixation, irreversible methods of operation, etc.

A point was brought out in the debates whether, in the long run, an industrial economy does not need a consumer-oriented society with greater number of people for sustaining the industrial production. It was felt that, in the short term, India may need population control programme for achieving accelerated industrial development. It was, however, doubted whether the short-term considerations could be embodied in the form of a long range policy and whether the State should encourage certain irreversible practices in the name of national interest.

A further point was made that the family planning policy has not succeeded as yet in making the family planning programme as a people's programme. This seems to be still a government programme conceived and operated by the bureauracy. The programme would become a people's programme only through sustained efforts in educating people to

get rid of some of the outmoded values of a feudal pastoral society such as son-complex, fears of maintenance in old age, "more hands mean more earnings", etc. A radical change in such values would become possible when, instead of facile and meaningless slogans, we have a radical change of environment and climate of opportunities for education and emancipation of women through employment. It was realised that we need not go back upon the family planning policy as such. But there was a wide spread feeling among the participants in the seminar that the policy needs to be changed towards making it more comprehensive, intensive and inter-related with other activities of the government leading to the promotion of family well-being as a whole, Many participants were of the view that, instead of family planning being a clinical-oriented, isolated programme, it should be a package of programmes connected with health education, welfare, social security and employment, administered in a co-ordinated manner by the several departments of the Government.

While the family planning policy is necessary and desirable, two further points were made about it. (1) The policy has not yet become part of the philosophy of life among the people. (2) The results are not commensurate with the investment. Elaborating these two points, it was felt that the pre-occupation among the policy-makers with family planning as a remedy to individual or national poverty and low per capita income, seems to cause a high degree of anxiety and cloud their minds as regards the methods to be adopted for achieving quick results. The policy-makers acknowledge that the common man must be given a choice to regulate his family and to have as many children as he likes; that the State should provide education and opportunities for the individuals to choose as a result of decision arrived at after assessing the advantages and disadvantage of having limited number of children. There was thus among the policy-makers a conscious emphasis upon education, the people being free to make the choice for themselves. Nevertheless, the time-bound target fixation approach seems to be running contrary to the above emphasis upon free choice by individuals. This happens because voluntary choice by individual family heads does not seem to produce satisfactory results. Therefore, a policy of rewards and punishments or incentives and penalties, seems to be pervading in the implementation of the family planning programme.

An important point was made by some participants when they said that the family planning policy should not over-emphasise the aspect of limiting the number of children but should place greater emphasis upon spacing the birth of children which would indirectly help in limiting the number also. In this context, a valid point was made about relevancy and the necessity of legalising abortion.

Emphasis upon limiting the number of children and the fixation of targets to carry on sterilisation operations, is sometimes resulting in ridiculous approaches such as employing agents to bring people for

sterilization purposes. Under this system, sometimes the agents bring inappropriate persons for operations and the doctors connive for fulfilling the targets. This seems to be an unhealthy approach and is a direct consequence of undue emphasis placed upon targets and their achievement on paper. Such a practice, it was felt, would not exist, if the family planning programme becomes part of a total health and welfare programme.

Some participants reacted sharply to this line of argument. It was said that two-thirds of the family planning expenditure is spent on medical care because medical care and family planning are very inter-related. Some participants also pointed out that the presence of medical practitioners in family planning work in the rural areas is accelerating the work of the preventive aspects of health programme. Doctors are not merely confining themselves to the isolated aspects of family planning programme.

Some participants emphasised that the family planning programme is made into a people's programme in so far as social workers, elected representatives in the *Panchayats* and *Zilla Parishads* are actively associated with the programme. Experience in certain parts of the country was also quoted to show that certain minority communities like Catholic Christians and Muslims are not resistant to the programme but they are reluctant to adopt certain methods. This reluctance should not be interpreted to mean resistance by the members of the community as a whole. It was said that the percentage of Muslims practising family planning was roughly of the same order as their proportion to the total population.

There was a feeling among some participants that results from the investment on the family planning could not be better than what they are so long as we work within the constitutional framework and adopt democratic methods of dealing with the problem.

Points and counterpoints about the policy have been brought into discussion, but there is an agreement upon the need for avoiding manipulations. The need for modifying the target-oriented clinical programme was highlighted. The present programme is misunderstood by the people because some leaders describe it as an alibi for failures on the economic front. There is a wide gulf between the common people and the workers in the field of family planning. It was said that the workers are misunderstood because they lack human approach and proper training. Inadequacies among the field personnel are also attributed to our educational system and processes which seem to result in a gulf in communication between the urban-educated and the rest of the people in the country.

A further point in this context which is of interest is that a stage had been reached when we should adopt some more subtle and sophisticated differential approach because in a country of continental dimensions like India, Assam is not the same as Haryana and there are vital differences between the North and the South-East and the West. Different classes also react differently to the programme. It was found that resistance was, by

and large, from the landless classes, from tribal people, from scheduled castes and from those who have been uneducated and unexposed. For these different classes of people, there is need for evolving programmes of different techniques with a different emphasis in methods of communication. The same programme does not seem to work well with all classes, communities, creeds and areas. With particular reference to *adivasis*, it was said that we do not have sufficient workers knowing their language, who can explain to them the message of family planning in their own language. It was emphasised that for the different groups, the approach should be directed to suit their way of thinking and their standard of living. The need for a sophisticated subtle communication and extension programme was emphasised over and over again. To suit the message to the various classes was of particular significance, and it was hoped that there would be, as a result of the seminar, a reorientation, reconsideration and re-motivation of the programme to suit the people at different places and levels of understanding and acceptance.

II

The Kerala experiment was explained in detail, by Shri S. Krishnakumar, District Collector, Ernakulam, who had organised a massive vasectomy camp at Ernakulam and was further planning to hold another camp in July, 1971. The paper entitled "Massive Vasectomy Camps—An innovative Project in Ernakulam District" had been circulated in advance and was the basis of discussion on the last day of the seminar.

Some participants raised the question whether, in view of the involvement of the District Collector, there was any coercion or compulsion used to get such a large number of people volunteering for vasectomy operations. Secondly, it was also asked as to the stage, where an educational programme ceased to be an educational programme and became an indoctrination, especially when the Head of the District Administration was involved.

In reply to this question, it was said that there was absolutely no occasion for any coercion and it was thoroughly a promotional effort by an army of officers, working day and night in the programme. In the context of conditions in Kerala, it was pointed out that people were aware of the need for family planning and it was a question of facilitating them to go to the clinic for operation. A team of officials and non-officials created a social conscience and a social climate about the programme. They were able to tackle each individual and identify individuals who could be persuaded to undergo this operation. The incentives offered were more in the nature of compensation for loss of salary for 8 days and to that extent, the incentive was not high.

There was also a mention about the enormous task of a doctor undertaking the responsibility for doing hundreds of operations a day. The

mobilisation of doctors needed for such a large number of operations as also the possibility of fatigue amongst the doctors, conducting such a large number of operations, were pointed out as some of factors which should be taken into account before such large-scale camps were organised.

Some participants felt that the camp was a success because the District Collector took the initiative and the responsibility. From this, it was felt that greater decentralisation of powers and responsibilities to the Collector to implement the programme, especially the financial powers, would lead to a great deal of success. The Collectors were considered to be the appropriate agencies for mobilising their people from all walks of life such as industrialists, businessmen, local leaders, *Panchayats,* Municipalities and the general public. It was, therefore, felt that the Central and State Governments should give him (*i.e.* the Collector) all the powers, particularly, the financial powers to conduct the programme.

Notwithstanding the conspicuous success in this camp, under the executive leadership of the Collector, some participants felt that the family planning programme should not be considered in terms of some executive action but as a programme of communication and extension. Several participants felt that this campaign strategy posed certain basic questions which had to be considered by the policy makers. Particularly, where would they like this strategy to be employed, and if so, at what cost ?

Some advocates of the campaign-approach were of the view that the campaign was not a mere executive action, but it was a popular mass movement. The campaign was intended to achieve results and fulfil the targets. It was pleaded that, if the campaign-approach was extended to the other parts of the country, the results would be very encouraging in the long run.

The campaign approach and the reactions thereto thus reflected a dichotomy between intensive action under Government leadership to achieve results and targets and the extension approach leaving the decision to the individual families to follow the methods that they liked. The insistence upon "irreversible"*operations was looked upon with scepticism by several participants. There was also considerable apprehension about intensive campaign approach as contrasted with a regular programme, though it was recognised that the intensive campaign could never replace a regular programme. A suggestion was made that an assessment of the cost-effectiveness of the campaign approach as against the regular programme approach should be made. It was also felt that in a campaign of this kind, cases might not be properly selected unless preparations were made long in advance. The technical aspects of the operations in a camp might not be satisfactory, and there might not be a proper follow-up of the cases for the camp. These deficiencies in the organisation of camps might lead

*The operations might be technically reversible but, practically the bulk of the people would hardly know about it.

to a slackening in the programme to a large extent. It was also felt that such camps may be occasionally organised; but if they were to become regular features, the staffing pattern of the camp and the costs of the campaign might have to be considered. Without camps like these, some felt that a simple prosaic educational programme might not convince the people. The camps need not be so large; they would have to be small. The educational campaign approach might be appealing, but only the action-oriented campaigns could be practically useful. The organisational aspects of these camps, of course, required thorough attention. The camps provided an opportunity to the willing citizens along with the highest standard of technical facilities. However, without a proper follow-up, the results could be disastrous.

Some questions were raised whether the promoters who were given financial incentives were in the nature of touts. It was admitted that such a contingency might be there, but it was felt that the introduction of promoters had greatly helped the family planning programme in its success. It was suggested that in Maharashtra for a populaton of 1,000, there should be at least 15 promoters, if not 25. These promoters were the people who actually had contact in the villages. They did a sort of social work to keep personal contact with the people. They would help the famliy planning workers to find out the families having three or four children and who required operations, etc. The promoters gave such information only. If some incentive was given, they were likely to take much interest in the work and they would bring in more and more people for family planning operations.

If, instead of promoters, regular salaried people were employed, there was a fear that they might not take much interest in the work. Salaried people might prefer to stay in towns and maintain false diaries about their going to the villages. On the other hand, if we had village folk operating as promoters, they might do more earnest work because they could talk to the people in a convincing manner and convey the message to them.

Even though promoters might bring cases for operation, they would not be able to do follow-up work. We, therefore, should have trained midwives or nurses spread out in the villages. The promoters should be regarded as honorary family planning educational leaders. A certain honorarium might be paid at the end of a year or a specific period. It was also said that promotional work could be done by voluntary organisations under grants from the Government.

III

A point discussed in the seminar was that of the dual roles of two sets of personnel in the family planning programme. These related to the role of social scientists and extension officers on the one side and the doctors and administrators on the other side. It was felt that there should be a proper

delineation of roles and responsibilities between these two.

There was considerable discussion on the difficulties experienced by voluntary organisations, particularly in the matter of release of funds and audit of accounts. There was a strong feeling that the Government was not honest in its attitude towards voluntary organisations. They sought the cooperation of voluntary organisations but placed many obstacles in their way particularly in the release of funds and as regards audit objections. There seemed to be a feeling that the Government was helping voluntary organisations because they were starving for funds. This attitude was unhealthy. The Government authorities followed very slow and tardy procedures in the matter of release of funds. Other Government departments getting finances from the Central or State Governments might tide over these tardy processes by relying upon overdrafts or re-appropriations etc., but voluntary organisations did not have such facilities. Therefore, delays in the release of funds to voluntary organisations worked havoc in respect of their activities. Secondly, the auditors required meticulous procedural conformity while examining the accounts maintained by voluntary organisations. It was very difficult for voluntary organisations to keep highly qualified accountants and clerical staff for maintaining the accounts in the same manner as in a Government department. Most of the voluntary organisations were run by honorary workers whose knowledge about Government procedures was very meagre. For these reasons, it would be more desirable to have commercial audit of the accounts of the voluntary organisations rather the stereo-typed system of audit by Government auditors. For these reasons, the representatives of voluntary organisations felt that the Government should make it plain whether they wanted the voluntary organisations to be associated with the family planning programmes or not. The present attitudes and procedures would make it difficult for voluntary organisations to associate themselves with the family planning programme.

Again and again, the idea came up that an integrated community health approach was best suited as a base for the family planning programme. Unless the families were assured about the survival and health of their existing children, they could not be persuaded to undertake birth control measures. In order to ensure this, one of the participants mentioned the experiments conducted by him under what he called "family survival insurance plan". Under this plan, certain hospitals located in representative areas were taken up; and 100 to 200 families were selected and attached to the hospital. The insured had to pay a nominal charge of Rs. 3 to 5 and they got all the medical facilities from the hospital for the five-year period. It was found that more and more people are joining the scheme and it was felt that such a programme as this was likely to attract large number of families. Finally, a point was also made that it was much wiser to prevent population explosion so that the programme of health

education, health and social security approach could be adopted than wait until explosion took place and then carry out the sterilisation, vasectomy, operations, etc., etc. The drastic step of sterilisation should be resorted to as a last measure, but it would be much wiser to take preventive steps to prevent explosion of numbers.

Many points were made about the administrative difficulties. These related to decentralisation, delegation and personnel. It was said that procedures should be simplified and there should be a greater delegation of authority and responsibility for encouraging the field level personnel to show initiative and enterprise in the programme. More than all these, there was considerable discussion about the persons to be recruited for conducting family planning operations. There was a debate whether educational qualification or enthusiasm and a missionary zeal should be considered as relevant for work of this kind. It was felt that, by and large, when family planning workers had to work in the rural areas, enthusiasm and a missionary zeal should have greater relevance than mere educational or technical qualifications.

One other feature which hampered the personnel from commitment to work was the temporary nature of the jobs offered to them. A time had come for regarding the family planning programme as a long-term programme and to recruit staff on a permanent basis. Security of tenure and appropriate conditions of service would go a long way to motivate the staff in the family planning department for better performance. Security of tenure might have a salutary effect upon their zeal.

A feeling was expressed that reputed voluntary organisations and professional associations like the Indian Medical Associations should be encouraged to play a larger role than they were playing now in the programme. The All-India Medical Association was in a strategic position to motivate the doctors whether in or outside the programme by persuading them to spread the message of family planning either by limiting or spacing the children among their clients. A further point was made that the local population should be mobilised to select field workers because local leaders would be intimately connected with the local people and could do wonders. The *Panchayats*, *Panchayat Samitis* and *Zilla Parishads* should play a greater role provided, of course, they were brought into the net work of the family planning policy and administration.

Some final points that emerged from the seminar were that there should be a special study made of the cost-benefit analysis of the family planning programme; there was need for a change in our approach and in our methods. The family planning programme should be organised as a people's movement and in this context, voluntary organisations which were better organised should play a greater role. A further point was made that every married couple, and particularly, newly married couples, must get a pamphlet

explaining the family planning and family spacing message so that they would understand how they were going to bring up their families in future. A point was also made that the Community Development Department could be mobilised for this work, particularly because their work in respect of agricultural production had become more or less accepted. The Community Development Department could pay more concerted attention to family planning programmes, along with their programmes of nutrition, health and extension education.

THIRD SEMINAR

AUGUST 16—17, 1971

INAUGURAL ADDRESS

UMA SHANKAR DIKSHIT*

Mr. Chairman and Friends,

I am indeed very grateful to the Indian Institute of Public Administration for giving me this opportunity to associate myself with this last of a series of seminars on Family Planning.

The Institute deserves credit for getting together intellectuals from the academic as well as the non-academic field to review the family planning programme which is the boldest enterprise in social engineering ever undertaken in this or any other country. It seeks to change basic attitudes in a sphere of life which has traditionally been left to chance or to the natural working of the laws of human fecundity.

Such a programme calls for the highest expertise in conceptualisation, planning and execution. The Programme Administrators, therefore, welcome a seminar of this nature which enables them to come in close contact with leading academicians representing various disciplines as well as leaders of public opinion.

The subject of the seminar, "Family Planning Policy and Administration", has been very aptly chosen.

Administration has been described as the hand-maiden of policy. A discussion on the administrative techniques for the promotion of family planning must therefore, follow a clear understanding of the policy perspectives.

We, in the Government of India have committed ourselves to family planning as one of the main planks of national development.

I was glad to learn that, by and large, the participants in the last two seminars have endorsed family planning as a programme of vital importance. True, there have been some dissenting voices but the broad consensus has been in favour of family planning. I would go further and say that there is today a broad *national* consensus in favour of this programme.

Sometimes, some people cite the example of some periods of western history when a growing population turned out to be an asset in industrial development.

While I am all for learning from the West, I feel that we have to look

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at the specific features of Indian society and Indian economy which are quite distinct from what prevailed in Western societies.

In the West, a technological base as well as a capital base for a modern industrial society had been laid before a rapid increase in population. India—and many other parts of Asia—have not been so fortunate. We have a legacy of colonial under-development, leading to an unfavourable balance between the size of the population and the availability of resources.

We started on the road to sustained and planned economic growth after the pre-conditions for a rapid increase in population had been laid.

A distinguished writer has pointed out that while man is a consumer for the whole of his life span, he is a producer of goods only for a part of his life. Under conditions of acute under-employment—which have come about as a result of a variety of factors which cannot now be solved overnight—there is bound to be an adverse balance between consumption and production.

A comparison between the increase in the total national income and the much smaller gain in the *per capita* income should convince anyone that such an imbalance exists—and that it requires an urgent solution in the interest not only of the welfare of the individual but in the interest of the economy as a whole.

Undoubtedly, we must increase agricultural production and accelerate the process of industrialisation but if we allow the present rates of natural fertility to continue unabated, it will take many generations to attain reasonable levels of consumption. In fact, the continued low standard of living is likely to retard the development of resources and perpetuate a depressed state of economy. The rapid growth of population is in fact forcing the underdeveloped countries to spend an ever greater proportion of their national income on the maintenance of existing standards of living rather than on their improvement.

Taking into account the special factors in the Indian economic situation, the Government of India have felt that, side by side with the economic solution, there must be a demographic solution to the problems of the country.

This problem is, in fact, common to many Asian countries. It is therefore not a coincidence that other Asian countries, irrespective of political ideology, have also embarked upon a programme of family planning.

There are many other reasons that could be adduced in favour of introducing an element of planning in family life. It is only through the planning of families that the nation can assure to its children proper care and the opportunity to develop their personalities to the full potential.

Whether you look at it from the point of view of the welfare of the individual or the overall economic growth of the country, family planning is a positive factor in promoting both.

As I said earlier, a demographic solution must go side by side with an economic solution of India's problems. In fact, the two are inter-dependent.

The question then arises : Can we accelerate the process of reduction in birth rate? Our experience and the experience of many other developing countries so far has been that there is nothing to be pessimistic about. Nearly nine million men and women in this country have undergone sterilisation. In our country, even the educated often shy away from so simple a procedure as a tonsilitis operation. Yet millions have put themselves under the surgeon's knife for—not, mind you, curing themselves of a disease—but for merely preventing further additions to their families.

It is of course true that this is not enough but it is encouraging enough for us to hope that, if we adopt the right techniques, we can succeed.

Only last month, a month-long family planning festival was organised in Ernakulum and the response of the people exceeded all expectations. The organisers had expected no more than 20,000 people to come forward for vasectomy. The first few days showed that they had underestimated the response of the people. At the end of the month, nearly 63,000 persons from Ernakulam and two neighbouring districts had undergone voluntary sterilization.

What was the secret of this success? The dedication of the administration; a firm faith that the wide awareness that has been created can indeed be translated into practice; the success in securing active cooperation of all official as well as non-official agencies in the field not only of Health and Family Planning but all developmental fields—in short, the mobilization of all "change-agents" in society.

It is the identification of family planning with the total socio-economic and cultural change that alone can make it a people's programme. I do not regard family planning as a self-sufficient, isolationist programme. Its implementation is possible only when it is taken to the people as part of a total development package. It must involve all "change-agents", not only in the administrative structure of government but in all sections of leadership at different levels—outside Government.

We must think of new approaches, innovations, which are suited to the genius of our own people, to our own social and cultural ethos. In our country, voluntary organisations have always played a great role in stimulating social change. We regard voluntary organisations as full and equal partners in the family planning programme. This is not a mere pious declaration. In fact, we are encouraging these voluntary organisations and giving them financial and other support.

In the course of the last few years, a machinery has been created from the Centre to the remote village, to provide family planning information, motivation, services and supplies.

There are still gaps here and there in the infrastructure. These are

being expeditiously filled up. The success of the vast task of taking the message of family planning to a hundred million couples spread over hundreds of thousands of villages and towns will depend upon how far we are able to make it a real people's movement.

I cannot over-emphasise the need for a continuing review of our programme and exploration of new approaches in order to bridge the gap between the wide awareness and the actual acceptance with as much speed as possible. I hope that this seminar would come up with new ideas and suggestions for the administrators of the programme.

I further hope that the present series of seminars will be the beginning of a continuing dialogue between leading Indian intellectuals and the policy makers and programme administrators in Government.

PAPERS PRESENTED AT THE

THIRD SEMINAR

WORKING PAPER

V. JAGANNADHAM*

The two previous seminars held in the Institute (May 19-21 and June 17-19) have discussed several aspects of policy and administration in the family planning programmes. The papers contributed to the Seminars and the summary of the proceedings have already been distributed. In the third seminar, we are looking forward for a fuller discussion of the suggestions in the two seminars and any other new ideas.

Policy Resolution

The family planning programme has been conceived and operated, by and large, as an administrative programme at the central and state government level. No doubt, there have been committees and conferences of Ministers concerned with the subject at the ministerial level as well as at the departmental and operational levels both in central and state governments. The working of the programme comes up for discussion in the legislatures at the time of budget. It is for consideration of the seminar whether any new devices may be adopted for the formulation of the family planning policy as distinguished from those that already exist.

Primarily, the seminar may discuss

1. Is there need for a resolution on the family planning policy to be adopted by the Central and State legislatures?
2. How to integrate family planning policy with health, education, social welfare and social security policies of the government?

Approach and Methods

A review of the current approaches and methods under the family planning programme reveals that the family planning department makes known and makes available to the people the various accepted methods, such as condom, pills, jelly, IUCD, vasectomy and tubectomy. By and large, people could make their own choice. However, an impression prevails that, with a view to realise the objective of narrowing the gulf between the economic and population growth rates, certain targets are fixed for being achieved by the field organisations. With a view to achieve these targets, the current emphasis has been upon motivating the people through

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cash and other incentives to undergo sterilisation. The sterilisation programme is carried on in certain States on a vigorous campaign basis. While, as a short range method, this may have its appeal for the achievement of targets, as a long range policy, however, there have been serious misgivings about the mobilisation of state resources for achieving targets through irreversible methods, such as, sterilisation. A feeling has been expressed that, while the state may make available all facilities for the people to adopt family planning techniques, it should not encourage the mobilisation of state apparatus for carrying out irreversible operations. The issues are:

1. How effective are the shifts in emphasis from the clinical approach to the cafeteria approach and now to the camp campaign approach. Are these shifts in emphasis helpful to strike a balance between the national requirements and citizens's right to choose?
2. So far, the emphasis in the family planning programme has been on limiting the number of children. It appears as though there has not been an equal emphasis upon spacing of children, particularly by the newly married couples.
3. What devices should be adopted for reaching the newly married couples and for helping them to space and limit the number of children?

Personnel and Procedures

(1) Many studies have brought to light the fact that temporary insecure conditions of employment of the personnel under the family planning programme are a great source of concern for the employees in the programme. How is it that the employees are recruited on a temporary basis when the central government has underwritten the programme for a period of ten years? Moreover, they may be handicapped in their programme of work, particularly in the rural areas, when certain extra facilities are not provided for them to go and work with prospective clients for the programme on a family to family basis.

What are the changes in the service conditions of the staff necessary for securing better performance?

(2) The training for family planning programme workers also seems to require a greater orientation towards social work techniques, and extension approaches. Probably, it is also necessary to consider whether without the requisite prescribed educational qualifications, local people with enthusiasm could be employed on a fairly long standing contract basis for carrying out the message of family welfare, family limitation and family spacing, to the people, both in rural and urban areas. Not only the lay motivators but the medical and para-medical personnel also require training and orientation both for initial and follow-up activities.

What are the changes in training and orientation required for the administrative, medical, para-medical and programme promoting

personnel in the family planning department?

(3) The family planning programme has so far been a centrally sponsored or centrally assisted programme. This kind of arrangement may have to continue for a long time to come. The central sponsorship has probably led to a donor-donee relationship between the centre, and the States as also between the State and voluntary organisations. Considerable time is consumed in approval, sanction and releases, etc. There does not seem to be much scope for initiative and enterprise on the part of local field officials unless they bring to bear an extraordinary missionary zeal. Bulk of the officials at the field level may take it as a part of their many and various duties and give only a routine attention to the family planning programme.

What modifications should be brought about in the existing scheme of administrative arrangements to bring about a greater sense of initiative and enterprise on the part of the field organisations?

Voluntary Organisations

There is a growing realisation that without the active cooperation and involvement of sound voluntary organisations in the family planning programme, it would be difficult for the government departments and agencies to carry through the programme successfully. Experience, however, shows that the government's attitude towards voluntary organisations is vacillating. On the one hand there is exhortation and on the other, there is reluctance in seeking cooperation by being prompt and expeditious in releasing grants and equipment. Such an attitude has brought about a feeling among the voluntary organisations that the government is not keen about enlisting their cooperation on terms of equal status. Moreover, very few voluntary organisations are in a position to comply with the requirements of accounts and audit procedures because they do not employ clerical staff for the purpose. The honorary workers in charge of voluntary organisations are also new to the proforma and procedures under the government. For these reasons, there has been an insistent demand for a separate grant-in-aid code, which would expedite and simplify the rules and procedures.

Do the existing attitudes and procedures towards voluntary organisations and for giving grants to them for enlisting their cooperation need modification?

Legislation

There is a feeling that abortion legislation would bring about far-reaching changes. The acceleration of the process of industrialisation and urbanisation seems to call for recognition of the right to demand abortion. This may, incidentally, facilitate the limitation of the growth of numbers.

In the light of the indirect benefit that may accrue to the family planning programme as a result of the right of abortion, it may be useful to consider the merits and demerits of the recent legislation.

1. Is the recently adopted legislation satisfactory or does it need modification?
2. What kind of safeguards should be provided for ensuring the safety of the clients who seek abortion?
3. Whether, after the legislation, the family planning department could adopt any extension methods to make the provisions of the Act known to the people?

POLITICAL ASPECTS OF FAMILY PLANNING

J. D. SETHI*

Population growth is both socially determined and socially determining. It is both a dependent and an independent variable. Similarly, population control policy is also a dependent and an independent variable. The very scope and thrust of a population policy depends upon the given economic culture. An economic culture of a developed economy of industrialization, urbanization, individualism, etc., is bound to create an attitude to the size of the family which is unlikely to create the problem of excessive population growth. On the contrary, it may create a problem of slow birth rate and labour shortage. It is in the formation of this economic culture that long term family planning can be made a continuous and growing programme.

Although government which is able to manipulate economic and social variables should also be able to control to some degree the population parameter, it would be too much to expect that the government can really bring about a drastic change in the birth rate although it can radically change the relationship between the birth rate and the death rate in one direction. Historically, birth rate has responded very slowly to even those variables such as modernization, industrialization, urbanization, etc. because there were not population policies followed by the governments in the 18th and 19th centuries. For example, the United States of America had no population problem before 1966. Similarly, in the absence of modernization, industrialization and technological development, the birth rate is going to respond very slowly to government's population control policies. But modernisation and industrialisation are vastly influenced by political structure and the role of active political variables is great in these fields.

The Government of India's approach to family planning has been basically similar to its approach to economic development. Left to the forces of *laissez-faire* in market mechanism, the Government argued, that economic development will be slow, distorted and unable to answer the sort of questions the nation asks. Similarly, it was the official view that left to unguided individual and group motivation, the slowly changing socio-economic structure, politicization of groups with narrow loyalties, etc., family planning and planned parenthood will remain stunted and distorted.

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Resistance to family planning like resistance to rational and economic development has come from various political interests. Political resistance to family planning has come from three sources : (1) Left Parties of various hues, (2) state and local power structure, and (3) ethnic and religious groups.

The Leftist objections to the popultion control are both crude and sophisticated. At the elementary level, it is their view that in capitalist countries all theories which include manipulation of birth rate are the direct descendants of the Malthusian Theory of Population and this theory, the Marxists suggest, has historically been a substitute for delayed social and economic reforms, if not for revolution. It is this delay in reforms that in the very first instance produced the population problem by economic exploitation and thereby slowed down the growth rate. No matter what the origin of the Malthusian Theory was and whatever its motivations, no Marxist could ignore the fact that for modern developing societies, the basic size of the population at a point of time, when a country begins its programme of economic development, is of crucial importance. If the size of population is large and even if the current rate of growth of population is not high, the country faces a certain built-in force against raising the rate of economic growth. Malthusian Theory had nothing to say about the population base and for densely populated countries like India. A large population base should be the major starting point of any scientific population analysis.

At a little more sophisticated level, it can be argued that if the size of the reserve army of labour which, according to leftist is the main source of exploitation, is very large, then the capitalist class should prefer to keep it at that level to keep the wages depressed instead of promoting population control. It so happens that in all capitalist countries, population control is accepted as an official policy.

There are other arguments that can be advanced to refute the pseudo Marxian hypothesis. Firstly, population control and family planning are accepted as a part of the overall policies of social reconstruction in all communist countries. Secondly, a country which begins with a large labour force but a small capital base will be forced to adopt labour intensive techniques, depend upon small-scale industries and will take a much longer time in the widening and deepening of capital, etc. All this is because of the slow rate of accumulation of economic surplus. No Marxist can support either this type of process of development or this rate of accumulation. Thirdly, it should be clear to left parties that a government which is able to manipulate economic and social variables to meet the needs of industrialisation, modernisation and development should also be in a position to manipulate birth and death rates. Fourthly, in countries which have about 70 per cent of population living in rural areas and also need major agrarian reforms, the policies and programmes of such reforms

can be defeated if not accompanied by population control. Finally, the scope for revolutionary consciousness is very limited when the population structure is Malthusian in character and economy is depressed. It is only when the society is getting out of the Malthusian model that people's aspiration and political consciousness undergoes a qualitative change. Since population control by itself cannot bring about a shift from economic stagnation to rapid growth, the leftists have nothing to lose and everything to gain by supporting population control policies in a developing society like that of India.

Nevertheless, the Government has to wake up to the fact that the Left Parties have been successful in creating the impression in many areas, particularly in backward areas, that the Government of India is using family planning as a substitute for social and economic reforms. The Government obviously has no such policy or intention but if such an impression is created, the Government has nobody but itself to blame. Some of the most urgently needed and long overdue reforms have been neglected or postponed by the Government for so long that many other programmes like family planning rightly become suspect in the eyes of the people. The Government should realise that delayed reforms mean delayed modernisation and stunted economic growth and in the long run, it is economic modernisation and high growth rate which create a value system which generates attitudes for having small families. There are many vested political interests which by forestalling economic reforms are sabotaging the population control programme of the Government and since quite a substantial section of these vested interests belongs to the ruling elite in the country, failure of family planning is assured in advance. Thus, though the Leftist view on family planning stands on very thin ground, their political objection deserves consideration because postponement of the economic and social reforms itself has created a confrontation instead of a consensus on family planning.

Population growth is becoming a threatening political issue apart from its economic and social effects on the programmes of development. It is rather strange that although the political parties and their leaders in their professed programmes, election manifestos and policy statements seldom include any definite approach to the population problem, they are constantly being subjected almost everyday to the growing demands of a fast growing population.

The demographic element in Indian politics can be very easily noticed in the growth of populist politics. A populist politics is the politics of the street in which people of almost all classes participate in bringing into disrepute both the social system and its ruling elite, not necessarily to change the system in any better way but to undermine it, no matter how good or bad. The demographic pressure adds to the number of people in the labour force and if the economy does not grow very fast, then

the unemployed reserve army of labour becomes an explosive political force. Those who are unemployed cannot generally form themselves into a pressure group. They normally work through other institutions and groups such as castes, political parties, religious groups, etc. which get excessively politicized. It is generally not realized that there is a very perverse relation between politicization and demographic pressures. This relationship militates against the stability and the functional elements of the system. Since the swollen labour force cannot get profitably employed, the politicization of their demands leads to pressures being built up on the government to enlarge social services such as education, health, etc. The greater the degree of unemployment, the more vocal the demands for expansion of education and other social services, thus further adding to the problem of unemployment.

Political leaders in India have never taken seriously the need for a population policy. There are a number of surveys to show that the political leaders at the local levels, where politics could have an immediate impact on the size of the family, have been extremely reluctant to impress upon their constituents the need for having small size families. The fault is not merely with the local leaders. Even at the national level, at a time when the birth rate was 40 and the death rate about 27, lack of urgency of population control on the part of the national leaders was reflected in the pitiful allocation of Rs. 14 lakhs for family planning programme in the First Five-Year Plan. Although the expenditure subsequently increased, it was only in the Third Plan and afterwards that the population policy became a national policy.

There is also the problem of superannuated leadership sticking around politics and carrying it on with all their past predilections and prejudices. The old leadership neither had a chance to practise nor had a belief in having planned families of limited size. Their credibility with the people could not be very high if these leaders preached restraint on the number of children produced. The new leadership which is comparatively younger has no urgency to look upon population control as an important policy. Recently, another political prejudice has developed against population control. One of the Ministers of Tamil Nadu had recently complained that as a result of the State vigorously pursuing a population control policy it has reaped serious disadvantages. According to him, the State is being punished just because it has been successful in following the vigorous population control policy. These disadvantages accrue in two ways. One, since a large amount of Central Government's fiscal policies in respect of share of taxes, grants-in-aid and subventions are based on per capita basis, the States with lower birth rates get less. Secondly, the number of seats allotted to a State in Parliament is also related to the number of voters. When the number of voters declines, the number of seats declines too. This is a clear disadvantage although the change cannot be very large even

over a decade. A similar problem recently arose in Ceylon too. The Health Minister of a previous government, Mr. E. L. Senanayake said in 1969 "that the state-sponsored family planning programme in Ceylon threatens to a halt as the Sinhalese oppose the move because ultimately they would be reduced to a minority as the Indian Tamils, the Moors and the Catholics have been exhorted by the leaders not to practise birth control." A similar attitude prevails among the Muslims in India who have not co-operated very enthusiastically with the family planning programme. Now it is the turn of Hindus. Many Hindu leaders have started advocating against family planning because they share the fear of Mr. E. L. Senanayake.

Therefore, it is very clear that unless the basic determinants of individual motivation to have limited families get developed fast, political, ethnic and religious interests would introduce contradictions in any family planning programme.

There is no reason for any State to feel upset about its long-term share in the political power structure on grounds of population control because of two reasons. First, there is bound to be impact of one State upon the other and no national programme of family planning can run to different extremes in different States. Second , the population ratio of different States is changed very much these days by considerable migration of people from one State to another. Migration has become a very important variable of the size of population of a State.

States like Andhra Pradesh, Tamil Nadu and Punjab, which have moved one step down in the ranking of States on the basis of population size, are also the States which are economically very strong States. It can be said with some confidence that, had these States not pursued a successful population control policy, they would have had to divert resources from development to maintenance of larger size of population. These three States have also got a very large share of the economic resources of the country on the basis of their economic strength and not because their population is small. Therefore, there is no reason for these States to worry about the adverse impact of family planning programmes.

Similarly, there is no reason for minorities to get worried about their share in total population because as minorities their influence in the society is more a function of their economic progress and social development rather than of their numbers. Small minorities like Sikhs and Parsis which are economically very strong and prosperous, enjoy more influence than their share in population would suggest.

It is strange that minorities like the Muslims should oppose family planning programmes on religious grounds when their brethren elsewhere, including Pakistan, are following family planning programmes. Similarly, there is no justification for the Communists to oppose such a programme as almost all Communist countries are practising birth control. The Christian world has been rocked by the contradiction between the needs of

planned parenthood and the religious dogma of the Catholics. But slowly, the Christian countries are moving towards a general acceptance of family planning programmes.

Although the Government of India has provided Rs. 315 crores for pursuing the policy of population control in the Fourth Plan, the programme may not turn out to be very successful if political and religious prejudices keep multiplying. In fact, the very success of the programme depends upon the political leadership accepting it was a major plank of policy at all levels.

SUMMARY OF PROCEEDINGS OF THE THIRD SEMINAR

V. JAGANNADHAM*

In his welcome address, the Director thanked Shri Uma Shankar Dikshit, Minister of Health, Family Planning, Works and Housing, for giving the Institute necessary funds to organise this series of seminars on the important subject of family planning because it gave to the Institute another area of national interest to discuss. He also expressed the hope that, as a result of the deliberations of this seminar, some ideas might be thrown up which will be helpful for the Ministry in formulating its policies for the future. Programmes and policies cannot remain static and they have to change according to the changing circumstances. The Director also expressed the hope that the Ministry will encourage further seminars and other forums for discussion in future.

Prof. V. Jagannadham, Seminar Director, described the third seminar as the apex seminar on Family Planning Policy and Administration. The family planning programmes had to be examined in the context of the current efforts to minimize poverty. Prof. Jagannadham also drew attention to the working paper prepared for the current seminar and requested the participants to put across their viewpoints keeping in view the issues framed in the working paper.

Shri Uma Shankar Dikshit, Hon'ble Minister for Health and Family Planning, referred to some of the salient achievements under the family planning programme in the last few years and said that the successes were due to the dedication of the Administration. In the course of the last few years, a machinery has been created from the Centre to the remote village to provide information, motivation, services and supplies in the area of family planning. There were, according to the Minister, still a few gaps here and there in the infrastructure, which had to be expeditiously filled up. He expressed the hope that the present series of seminars would begin a continuing dialogue among leading intellectuals, policy-makers, and administrators, The Hon'ble Minister also pointed out that, in the initial stages, the programme had an administrative orientation because the leader-

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[1]The Third Seminar, which was the concluding one, was divided into three Sessions, the name of the chairman of each session and the names of the speakers are given in the summary unlike in the first two Seminars.

ship was provided by the Central Government. He suggested that in order to make the programme more effective, the seminar may bear in mind the following propositions :

1. Since the entire programme had to be carried out by the States, leadership at that level had a great significance.
2. It was necessary to discuss the family planning programmes with each State Government separately as well as with all of them collectively.
3. We must adapt the programme to suit the local and special circumstances without considering which no progress could be made in this field.
4. A joint effort between Governmental and non-Governmental organisations was also required to further the family planning programme.

The Hon'ble Minister wanted the Administration to profit from the wide awareness about the family planning methods and techniques amongst the people. According to Shri Dixit, the wide awareness was rather of a peculiar nature. If the people had completely understood the importance of the family planning programmes, they would certainly have availed of the facilities being provided by the Government. In this sense, the awareness did not seem to be complete as it did not give evidence of individual conviction and was not leading to practical pursuit for adopting the family planning practices. In the light of this feed-back, the policy makers had to put in greater and wider efforts to reach the people's mind, carry conviction and give them greater information and better services. Then alone, would the people fall in line with the objectives of the programme and cooperate in achieving the targets. The Minister also expressed the feeling that possibly the slower the initial reaction, the more active would be the response at a later stage. He pleaded for trusting the people and facilitating them to get more involved and participative in the new economic and social programmes.

The Minister was aware that some new ideas had been thrown up in the last two seminars and he hoped that more new ideas will be thrown up in this third seminar. According to him there was great need for achieving integration and as such, the task before the Administration was to collate, coordinate and synthesise the various suggestions for purposes of implementation. He also wanted identification of purpose and concreteness in suggestions so that the Administration could implement the programme.

FIRST SESSION

Chairman : Dr. D. N. Pai

The first session was presided over by Dr. Pai, who listed the following points for the consideration of the seminar :

1. The problem of organisation of family planning programmes

essentially involves an approach of taking the programme to the people. The family planning programmes would be successful only when Administration succeeds in taking the programmes to the people instead of concentrating on some symbols. This calls for the greatest of endeavours. The five important elements of organisation in Family Planning are :

(1) *Survey : i.e.* to identify the various people and their needs.

(2) *Motivation :* That means, trying to diffuse meaningful information or creating awareness leading to knowledge and conviction so that conviction precipitates into desirable action.

(3) *Service :* Family Planning is a service which has got to consider the convenience of the people. This service has to be offered in a convenient form and the Ernakulam experiment is an eloquent example of the convenient way in which the service could be offered by planning and providing all organisational inputs.

(4) *Follow-up and Feed-back :* Follow-up is the backbone of ensuring success in the family planning programmes. If the follow-up is not proper, any number of programmes will not be able to achieve the desired objective. As such, follow-up and feed-back service has to be given the utmost importance.

(5) *Involvement of the people in the programme :* People must be involved in the whole programme. The trouble is that we are obsessed with doing things without caring to study the satisfaction derived by the people.

After brief introductory remarks the Chairman of the Session, requested Prof. Jagannadham, the Seminar Director, to introduce the working paper which had been circulated earlier. Prof. Jagannadham explained the pros and cons of adopting a policy resolution on family planning by the Central and State legislatures. He also referred to the need to discuss the appropriateness of the target fulfilment approach and the soundness of the present personnel policies and procedures. He further said that in addition to the issues listed in the working paper, other relevant problems could also be raised.

The Chairman then threw open the discussion and invited the views of the participants on the need for family planning policy to be adopted by the Central and State legislatures.

Shri Ambasankar, Secretary, Health and Family Planning Department, in the Tamil Nadu Government, pointed out that the Tamil Nadu Government adopted the family planning policy about 13 years ago, thanks to Mr. Gopalaswami, I.C.S., who was then the Chief Secretary of the Govern-

ment. They had really wanted to put the programme on a statutory footing so that the change in governments should not mean change in the family planning policy. In fact, the Madras Panchayats Act of 1958 raised two important points; one relating to food production and the other relating to the family planning programmes on a statutory basis so as to ensure reduction in population. Increase in food production and reduction in population were the two focal points of that Panchayat Act. Panchayats were charged with the two-fold responsibility of increasing food production and reducing population size. This had not been done in other States. He commended this idea for implementation in other States also.

Mrs. Tarakeswari Sinha pointed out that the bottleneck in the family planning compaign emanated from the fact that the programme was still considered to be an official programme following all the known patterns of administration. This had resulted in making the programme a departmental affair and not a people's movement and the family planning programme could be made a people's movement in the country like the *khadi* movement and the movement for the emancipation of women. This would create an impact for effective implementation of the programme. She regretted that the question of family planning had been taken lightly and even members of Parliament did not attach serious importance to this question though it was a question of life and death for the nation. The urgency of the problem had not been brought home to the people. She wanted the Seminar to make a departure so that immediate impact could be created in the government and also outside the government. She welcomed the suggestion of legislation which should take the shape not merely of resolution but of a comprehensive legislation about orientating the family planning programme to achieving the objectives.

Mrs. Sinha wanted the Government to take the initiative and bring the family planning programmes under the charge of a completely autonomous body. The programme would then have a better link with the people without the direct interference of governmental agencies. Autonomous organisations should be given discretionary powers to take action so as to mobilise the programme according to the needs and to arrange and reorientate the programme to the demands of the situation. She stressed the need for a comprehensive legislation for creating an organisation with wide powers and sufficient funds for reorganising the system. The Family Planning Programme had become bogged down because of the conventional system of administration which also adversely affected the functioning of voluntary organisations.

Why the sterilisation programme was not making much headway also needed to be considered seriously. Mrs. Sinha stressed that all the cross-sections of the people that she knew including the villagers in the most backward areas wanted to have the operation but since the normal formalities of conducting an operation took about a week, it was extremely

difficult for women to leave their families for this long duration to undergo the necessary operation. Most of the people did not want to have the risk of having children in excess of what they could afford—not more than 2 or 3. She stressed the need for taking the programme to the people and adapting it and tailoring it to meet their needs. This would ensure success for the programme.

In order to take the family planning programme to the university and college students, perhaps it would be necessary to prepare science fiction programmes which would indirectly touch upon the need and the ways of family planning. Even a fiction-like film on family planning would attract the younger generation. She suggested that some money should be set apart for making interesting films on family planning which should have a full-fledged story so that the people may have full satisfaction as well as knowledge about family planning. Many children saw television; they were very sensitive and the visual impression was greater than sound impression. They easily would pick up these things when they see them on the television. Therefore, imaginative schemes oriented towards this type of films on family planning appealing to the visual sensitiveness of the younger generation should be attempted. The generation gap was becoming wide but unless we produced something which comes up to the expectation of the younger generation, they were not likely to accept what we might say. Imaginative programmes were required; otherwise, all the money which was being spent would be wasted.

The voluntary organisations also had a tendency to be power-oriented. All the voluntary organisations had been geared to sustain themselves out of the grants of the government. Their only expectation today was to get as much grant as possible. If they found that the Health Ministry would give them some programme, most of the people in voluntary organisations would look upon the Health Ministry for getting grant for that scheme.

Mrs. Sinha wanted Government to take the help of those voluntary organisations which were still maintaining their tradition by maintaining themselves out of conviction and not merely because of governmental grants. Most of the voluntary organisations had become parasites. Whenever you talked to them, their first problem was of grants to initiate any new work. Their main concern was how they would be able to get the grant to support them. That was why no national movement had been started. Voluntary organisations required not only grants but dedication of the workers to run them. Therefore, there was need for an assessment of those voluntary organisations which were active. The governmental agents must go to them and not expect those organisations, to come to the Government.

Mrs. Sinha wanted the Government to take the initiative to find out voluntary organisations which would do work in the field of family planning

out of conviction and then help them in organising such programmes.

Mrs. Damodara Menon suggested that if the seminar was recommending the discussion of family planning policy in Parliament and State Legislatures, it should be something more concrete than just the discussion of the policy. The issues involved were vital and as such, she suggested that a statutory programme be tagged on to the Policy Resolution so that the discussions could be meaningful.

Mrs. Menon said that there was need for close coordination between Government and non-government organisations. At present, the non-official agencies were completely ignored. The only way to make the programme bigger and more successful was through the help of voluntary agencies and this was based on Mrs Menon's experience of the programme in Kerala where the consensus had been achieved primarily because of the close coordination with the non-official sector.

As regards grants-in-aid programmes, Mrs. Menon felt the need for a new approach. Rules and regulations were essential but these should not lead to the stifling or harassment of voluntary organisations. Many organisations which intend to help the family planning movement were unable even to continue the old activities because of bureaucratic curbs put on them. The Central Social Welfare Board's grant-in-aid Code was not likely to be useful as very few people would contribute for family planning programmes. Rules and regulations should be so adjusted that, without giving a free hand to voluntary organisations to spend, a free hand could be given to them to work better with money which was already available to them. As regards the programme itself, Mrs. Menon was of the view that the family planning programme had to become a part of education at the high school level. It should not be family planning as such but it should be problems of over-population, leaving aside clinical and other areas of family planning. Mrs. Menon also suggested that a small wedding present to all people who get married should be made in the context of family planning programmes. This could be a small booklet on aspects of family planning and should be made available at the time of the celebration or registration of the marriage.

As regards personnel, Mrs. Menon felt that the Health Ministry should decide about the organisational patterns in family planning institutions so that the clamour of temporary employees was not allowed to affect the programmes adversely.

The medical aspects of the programme also should be varied. Today sterilisation might be popular but a time might come when that might not be relevant. As such there was a constant and continuing need for modification of the family planning programmes.

The Chairman wanted the discussion to be focussed on the need for policy discussion at the Central and State legislatures levels which, in his opinion, was very important. Policy discussion of the problems even at

lower levels like States and Municipal Corporations would commit local leadership and generate enthusiasm amongst the people about the programme. As regards administration, he wanted the discussion to be focussed on the pros and cons of the Centre laying down a pattern for the implementation of family planning programme. In his opinion, this would prevent States from making any departure from that pattern and would thus stifle experimentation.

As regards voluntary organisations, the Chairman raised the question as to whether the grant-in-aid should be based on performance rather than on the basis of some principles of allocation of funds to voluntary organisations. If we were to gear up the grants to performance, many of the parasitical voluntary organisations would have to close down. Once accepted, a good deal of re-thinking for better action would take place.

Shri R. N. Madhok pointed out that, after a good deal of discussion, a pattern for financial assistance had been evolved. Under this pattern, all the major States got a grant of one lakh Rupees and smaller ones fifty thousand Rupees and within this amount, the States were open to advance assistance to voluntary agencies and other social organisations. These funds could be used for experimental schemes, and as such, the States were in a position to give funds to voluntary organisations which came up with their proposals. There was yet another scheme at the Central level for innovative schemes for which the proposals had yet to come from the States and voluntary organisations.

Shri M. Ramakrishniah pointed out that by merely passing a resolution in the Parliament or the State Legislatures, it would not be possible to increase the interest of the people in family planning programmes. It was not the lack of enthusiasm about discussing the problem and passing the resolution but the lack of seriousness which was the main problem. He was of the opinion that mere passing of a policy resolution would not help the matter. There was a Science Policy Resolution and an Industrial Policy Resolution, a Forest Policy Resolution and so many other resolutions were there. There were many fields in which no policy resolutions had been passed and yet things in those fields were progressing very well. So, it was not the passing of a resolution which would set the working in order. The problem was how to get the results as per the targets set. He was for a Policy Resolution that could indeed set the base for further action and that too a result-oriented action. The progress of the programmes in different States differed widely. Some States had achieved comparatively better results. Fiscal devices should be evolved to help such States. Even at present, large families were getting the advantage of rebate for purposes of income-tax. He wanted the seminar to make recommendations about the fiscal measures which would result in better achievements under the family planning programmes. There was already a general consciousness

and awareness of the need for family planning.

As regards voluntary agencies, Mr. Ramakrishniah expressed the view that the movement could not be created by a resolution. It had to be created by dedicated organisations. Why was it that the movement was not created and the established organisations were not contacted ? These were the real problems which should be looked into. Mr. Ramakrishniah pointed out that it was one thing to spread the awareness and to provide the services and yet it was another thing to organise all of them together and bring about a revolution. In his view, wherever the District Collector had taken interest in the family planning programme, there had been a remarkable consensus and as such, the District Collector would have to be the focal officer for organisation of family planning programmes.

Dr. S.N. Agarwala said that it was wrong to say that the family planning programmes had not been satisfactory. If we took the progress in any other country in Asia and if we compared it with our progress during the last three years on a percentage-wise basis, the progress made in India was superior to that of other countries. Still we were not satisfied with the progress of family planning. The reason was that we wanted to make still faster progress. If we could go deeper into the programmes and take the micro picture and not the macro picture of the States and Districts, the progress of the programmes was very immense. Out of 85 districts studied by Dr. Agarwal during the years 67-70, in about 30 districts, sterilisation targets had been exceeded. The IUCD targets were exceeded in 8 districts. The sterilisation target during 67-70 was 14.5 per thousand of the population but the progress unfortunately had not been uniform in all the districts. Further, the districts and the States where progress had been poor were the very districts where even agricultural production, industrial production, education and everything else was also lagging behind. These were U.P., Bihar, Rajasthan, Madhya Pradesh, Jammu and Kashmir and so on. The family planning problem was not an economic problem or a health problem; it was a problem of social evolution and social changes in the attitudes and norms and environment of the people. Changes in the attitudes were necessary. As such, the problems could not be solved merely by administrative action. What was needed was a social regeneration and this took time. No political party in India had so far made family planning as part of its policy. But we had to make the leadership available so that the programme could be a success. The administration of family planning programmes was a special kind of job. The administrator need not be a medical doctor or a reformist or a pure administrator. We required a person who was also a social crusader who could carry conviction with the social workers and others and who could have a political image also. There was need for research in this aspect and the Indian Institute of Public Administration could go to the districts and find out the qualities of leadership in those districts which had been rather poor in performance and find out the

reasons as to why the programme had not been a success in those districts.

Mr. Gangrade pointed out that the family planning programmes needed a fundamental change in the attitude of the people. At present, once more by imposing norms on the people, we were not involving the people to develop the norms. He suggested that the Policy Resolution from this point of view was important as it could help in changing the attitudes of the people. It might also help the governmental machinery. He wanted a discussion of the family planning resolution to be restricted to the Centre and State levels.

He also pointed out the need for integrated thinking in the context of not merely family planning but also welfare of the whole family. The family planning programme should not be confused with the medical programme as this did not allow the people to have a proper choice. Essentially, family planning was a problem of the society. The psychological problems faced by the people in the context of operation or sterilisation had not been looked into. Mr. Gangrade wanted a research programme directed towards locating the people with whom family planning programme could be a success.

Mr. K. K. Das, Secretary, Ministry of Health and Family Planning, made a few observations which he said were not necessarily the views of the Government. His personal feeling was that after going through the pros and cons of the Policy Resolution, the time was ripe for it to be adopted in the Central, State and Municipal Boards. There might be even some hostile areas but still in his opinion, the vast majority of the people were in favour of family planning and it would be possible to have as many forums as possible where family planning programmes could be discussed.

Mr. Das expressed the view that voluntary organisations were a very useful adjunct to family planning in this country. Family Planning began as a voluntary activity and possibly, after sometime, it would be taken over by voluntary organisations. The voluntary organisations did a great deal by way of education.

As regards sterilisation, Mr. Das expressed the view that though there was some hesitancy about sterilisation, yet it had been very useful and of much help, particularly, to people who had three or four children. Of course, the after-effects of sterilisation in some cases had produced psychic disturbances though female sterilisation did not seem to have any such effects. It had also been said that people were being brought in by incentives. This feeling had to be countered. It was for the seminar to decide as to how this kind of feeling should be countered.

Prof. D'Souza agreed that there was the need for a Policy Resolution in the context of integrated programmes of health, education, social welfare and social security. If family planning had to be a movement, this integrated resolution would provide the initiative. The Policy Resolution must concentrate on concrete positive message so that mass media could

utilise this positive image. The positive image must create involvement at all levels.

SECOND SESSION

Chairman : Shri N. T. Mathew

Shri T. N. Mathew, while taking the chair, suggested that he had been perhaps asked to take the chair so that a statistical approach might perhaps help to crystallise our ideas. The chairman said that there appeared to be complete unanimity on the policy resolution but there was no evidence to show that a policy resolution would help the family planning movement. We were convinced about the desirability of the programme though we did not seem to bother about the evidence. Mr. Mathew wanted to know whether the National Sample Survey could help the programme by collecting data either in implementing the programme or in evaluating the programme *i.e.*, its results.

Dr. Pai, the Chairman of the earlier session suggested that the Central Government was already committed to the programme of family planning and as large sums of money were really allocated to this programme, the problem really was one of involvement of the people and continuing the movement. In Dr. Pai's view, the clamour at present was not such as would call for a Policy Resolution.

Shri R. N. Madhok, while giving the history of the development of family planning programme in India, pointed out the various official pronouncements in the Plan documents as well as in other documents such as declaration of human rights, to which India was a signatory and he suggested that these could be interpreted as a policy statements. Even the President's address every year included a reference to policy about family planning. As such, he was of the opinion that there was already a full-fledged programme and the National Development Council had accepted that programme. As such, it was not clear as to what more was wanted of the Government. In his view, the urgent need in the matter of family planning was proper implementation rather than declarations or restatements of policy.

There was considerable discussion about the Policy Resolution* and the consensus was that the Policy Resolution needed to be adopted. The Indian Institute of Public Administration which was organising these seminars might be asked to prepare a suitable resolution which should be circulated to the participants of the three seminars for eliciting their opinions on the proposed resolution. This resolution could also take into view the need for integration of family planning with Health and Education.

The need for integrating family planning programmes with Health and

*See Appendix I for the Draft Resolution prepared by IIPA.

Education was discussed by the participants. Divergent views were expressed. On the one hand, it was pointed out that no family planning programme could be successful without taking an overall view of the Health, Education, and Welfare programmes. On the other hand, it was felt that it was difficult to see what the integration of programmes would possibly achieve. Another view was expressed that the Government of India had already accepted the need for integration of these programmes. The family planning programme of 1957, according to some, had a clinical approach. Later on, from the clinical approach, there was a shift to the extension approach and from the extension approach to the social scientist's approach, because it was thought that purely medical and clinical approaches would not deliver the goods. Family Planning could not be practised in isolation and it had to be part of the health programme. Social workers had an important role to play. Family planning actually consisted of two areas—motivation and service. For motivation, there was need for social security approach which was absolutely essential. At the same time, the actual process of family planning was said to be definitely a health programme.

While summing up the discussion of the second session, the Chairman emphasised the right of choice of the people who had opted for family planning. We could also make available to the couples whatever past experience had taught us and allow them to have their own choice.

As far as integration of family planning with Health, Social Security and Education was concerned, it was agreed that the trained social workers should be fully utilised. Not much was said about education and social welfare, but this was expected to be included in the Policy Resolution, to be drafted by Indian Institute of Public Administration for adoption by legislatures, etc.

As regards the approach and methods, it was generally agreed that there was need for screening and follow-up action in difficult cases. Though this was being done in Tamil Nadu and Kerala, it was necessary that this method was adopted in other States also. The consensus was that the sterilisation programme could not be termed as irreversible and therefore, this term should be avoided.

THIRD SESSION

Chairman : Dr. S. N. Agarwal

After taking the chair, Dr. Aggarwal requested Shri Sethi to present his paper entitled "Political Implications of Family Planning Programme". Shri J. R. D. Sethi, while introducing this paper, said that this programme might be examined from the standpoint of limitations and potentials not only from the economic point of view, not only from the point of motivation of individuals but also from the point of the types of policies as were being developed in this country. The programme was subject to all the limitations

of the economy but it could also be an instrument of bringing about certain changes in a limited sense. Thereafter, Dr. Sethi read his paper.

The paper was thrown open for discussion and Prof. D'Souza suggested that, instead of having a family planning policy, we should have a family welfare policy or simply, welfare policy. Family policy would place emphasis on family rather than on individual and the numbers. Common man felt in terms of his family. Therefore, it will be appealing to him if emphasis was on the family rather than on the reduction of number in the population. There was need for emphasis on education and strengthening of social services. The Chairman at this stage suggested that the discussion might be confined to Dr. Sethi's paper which had been presented earlier, and which emphasised that the left parties had come to dominate the power politics structure at the lower level and these groups were not giving adequate support for the family planning programmes. He had also brought out the point that while the Marxists were in favour of the family planning programmes, the capitalists were not. The left parties and the Marxists felt that the family planning programme was a programme which capitalistic parties had put up as an alternative to the policies and programmes of social development of the masses. Dr. Sethi's paper had also emphasised the problem of Muslims, Christians and other minorities and their views on family planning were apparently opposed to the family planning programmes. As such, unless the political parties were committed to these programmes and they gave serious consideration to the problem, the progress would be very slow. Dr. Sethi emphasised that unless the political parties were clearly behind this programme, we would not be able to achieve much progress. It was not merely the non-availability of resources which stood in the way of the programme. How effectively this money could be utilised in the implementation of the programme was more important, for, there were reasons to believe that even with smaller allocations results would be more conspicuous. It appeared that everything was being left to political leaders and bureaucrats; in the political system that we had, nothing seemed to move unless the programme was clearly demarcated between politicians, civil servants and bureaucrats. It was true that education and housing programmes would have much effect on family planning but the family planning programme could not wait for the provision of social services.

Dr. Gangrade said that it was true that there was need for political parties to pick up this programme but the question was how this could be achieved.

Mrs. Menon said that no useful purpose would be served by laying the blame on political leadership or the opposition. She suggested that the programme had already been accepted as a national programme and we should go ahead with the programme irrespective of opposition from some political parties which would always be there. She said that political implications need not be taken very seriously since it was a people's programme

and people at the macro level had accepted it.

Shri Ambasankar, pointed out that political implications were important as representation in the Lok Sabha etc., went down with reduction in population. The Finance Commission took stock of those things while making its recommendations for financial allocations by the centre to the states. As such, the amount that Tamil Nadu got was less as a result of an effective check in the growth of population due to successful implementation of family planning programme. The remarks of the Chief Minister of Tamil Nadu in this connection had not been made off the cuff but they were the considered views of the Tamil Nadu Government because the Central Government was not appreciating the necessity of rationalising the financial allocations and de-linking them from mere numbers or per capita basis. The Tamil Nadu Government had suggested that representation in the Parliament could be determined on the basis of 1951 level of population and the Finance Commission also could give additional massive grants for development but no reply was forthcoming from the Central Government. As such, some people rightly entertained reservations about family planning policies of the Government as they would be adversely affecting their representation in the Parliament and their allocation from the Finance Commission.

Shri R. N. Madhok pointed out that it was true that family planning programme had of course some political bearing since democracy, after all, was a game of numbers. Nevertheless, it was wrong to say that the Muslims had not accepted the family planning policy and many research studies showed that the Muslims were not far behind in accepting the family planning programmes. Even the Koran supported the view that one should not have a large family, if one could not support it. Under such circumstances, even abortion was permitted. By and large, all individuals were participating in the family planning programme whatever their leaders might say. Properly motivated and educated, individual families tended to take decisions in favour of limiting the family size.

Shri Madhok also rebutted the view that the left parties were against family planning programmes. In East European countries, though large families were encouraged in order to make for the losses in the Second World War, yet, abortion was permitted without many questions being asked. Abortion was free and other methods of family planning such as oral contraceptives and IUCDs were permitted.

Shri Pratap Kapur supported Shri Madhok and said that apart from realities of the East European countries, even the experience of the Ernakulam scheme showed full and total commitment of the communist government to family planning. This showed that there had been re-thinking in the higher echelons of communist countries. It was true that at a particular point of time, the Marxists were opposed to family planning because the attention got concentrated on non-economic factors but Marxists today

recognised the important role of demographic factors in economic development.

Dr. Kapur also pointed out that the political influence wielded by the States did not have much to do with the acceptance or non-acceptance of family planning programmes. The three best performing States, Tamil Nadu, Maharashtra and Gujarat today wielded political influence in respect of acceptance of family planning programmes because the influence depended upon economic strength. This in his opinion would continue. Shri Kapur also referred to the rigid position of certain religious groups. He was of the view that once the issues were based on clear-cut ideological terms, all the minorities would accept family planning. The birth-rate among the Christians was very low. Therefore if other religious communities such as Muslims were also convinced that they would benefit as a result of the adoption of the family planning programme, they would certainly accept it.

Shri K. K. Dass said that in any programme like Family Planning, the consensus depended upon individual preferences and it was a practical point whether the Government and the political parties had so much influence, so much power as to change the people's attitude. Hitler was very anxious to promote large families; he had a tremendous grip over population but the birth-rate remained negligible. Even in communist countries, in spite of the wishes of the Government, people went in different directions. Bengal and Kerala which had the biggest concentration of left forces were still doing very well in family planning. Other States like Bihar and U.P. were not doing all that well. As such, it was difficult to say whether the Government could help or hinder, whether the people had made up their minds in family planning or not. Family Planning was very much in the private sector. The necessary infrastructure was also available and this infrastructure depended upon voluntary organisations and as such, the success of the programme rested with the availability of infrastructure and the capacity of the voluntary organisations to popularise this programme. If the people wanted to take advantage of the infrastructure, it was available to them. Shri Das also pointed out that he agreed with the various points raised by Shri Ambasankar, Health Secretary of the Tamil Nadu Government as the Health Ministry did feel that there should be some incentives for good performance and disincentives for indifferent performance. He was of the view that 60 per cent weightage to population which was the percentage given for allotment of grants should be reduced to 50 per cent and the 10 per cent should be given for efforts in the field of family planning. How the effort in the field of family planning was to be judged was a matter of negotiations between the Centre and the States.

Shri Imtiaz Ahmed said that any decline in population would not really affect the total assistance made available by the Centre to the States during the next fifteen to twenty years. In his view, strong representation

of States in the Lok Sabha did not create the necessary influence at the Centre. In his view, this point could be illustrated by referring to U.P. which with all the representation in Parliament and with the vast numbers that it had, had not been able to make as much progress as other States. In his view, when political leadership was not committed to anything, much progress could not be expected. It was necessary to place considerable emphasis on political leadership and its role in following through the programmes. The strength of the individual States emerged from the economic level of their prosperity and not from mere numbers. It was the natural development which gave strength and influence to the States.

Mrs. Sinha pointed out that the apprehension in some States was based on the assumption that the family planning programmes would not succeed in U.P. and Bihar. This assumption was unwarranted and would be short-lived. She was of the view that the seminar would be useful if it could find out as to why some of the districts had not done well in family planning programmes. She said that it would not be possible for them to go into the details right then. Fruitful results could be achieved if the IIPA made a survey of all those districts and found out why they had not succeeded and suggested the assistance which should be provided to them—whether in terms of finance or social workers—so as to make the programme successful. The feeling was that the States which had not done well in the family planning programmes had also not done well in other developmental activities. Thus rapid growth in population had accentuated the problems rather than solved them.

Prof. D'Souza pointed out that if one were to think of family planning in the context of political leadership, minorities, religious groups, etc., there was bound to be opposition. He emphasised the view that the emphasis should not be on population control but on small family norms.

Dr. Agarwal, Chairman of the Session, while summing up, said that it was obvious that if we got political support for a programme like family planning programme, it could run much better, much faster and would be more acceptable. But the reverse that in the absence of political support, the programme would not be successful may not be correct.

Dr. Agarwal suggested that it would be a nice research topic to study as to why the members of Parliament and the political leaders were lukemarm in their support to the family planning programmes. As regards Muslims and Catholics, he said that amongst the Muslim countries of the world, nearly 70 per cent had accepted family planning policy after World War II. The only countries which had not accepted were those where the quality of education was very low and the rate of economic development was very slow. But most of them had adopted the population policy; so the situation was changing. In India, if the political leaders and the social leaders took the initiative, the progress would be much faster.

Dr. Agarwal felt that the relationship between the political leaders

and the bureacrats were like the relations between husband and wife and all were necessarily carrying out the programme. The politician must know the effects of the implementation of the programmes and the programme should not be left entirely to the bureaucracy or the administrators. It was essential that political leaders, private leaders and the civil servants implement the programme in its true sense. It was time that there was a general agreement between the politicians and the administrators, and then alone, one could run this programme or any other programme. There had to be a clear demarcation of spheres of work between the politicians and the administrators.

Dr. Sethi, summing up his reaction, said that the family planning was a programme of individuals and whatever success it had achieved in India had been, not because of the efforts of the organisation but because of the efforts of individuals, but he did not agree that the programme should be run by the bureaucrats only. It was unfortunate that bureaucracy was acquiring autonomous political power which undermined the political power. Hence in any system which undermined the political power and bureaucracy became powerful, not much progress could be achieved because this led to absence of touch with the masses.

Prof. Jagannadham, Seminar Director, while summing up the proceedings, thanked the Health Ministry, which had enabled the Institute to take up and hold these seminars, on a problem of much significance and urgency. He also thanked the participants who had attended the seminars. He expressed his gratitude to the chairmen of the various sessions for making the proceedings so successful.

While summarising the discussions, Prof. Jagannadham said that the consensus was that there was need for a resolution; the contents and the particulars of the resolution had to be worked out in detail and the proposed resolution would be circulated to the participants in due course. Actually, it was also decided to call the proposed resolution a statement. This statement would also cover the various points made in the context of the proposal to integrate family planning programmes with programmes of Health, Education, Social Welfare and Social Security.

As regards the approach and the methods of family planning programmes, Prof. Jagannadham drew attention to the growing realisation that we should respect the dignity and freedom of the citizen to choose the methods. As the administrative infrastructure developed, it would be possible to provide more facilities to the people and they would be in a better position to choose the particular method which suited them.

A question had been raised as to how the administration should try to reach newly married couples. In this connection, information was provided by the Ministry that booklets were already being distributed at the block level.

On the question of personnel and procedures, there had been

considerable discussion and Prof. Jagannadham expressed hish appiness that the Department had already issued instructions for making the staff quasi-permanent. There was need for providing incentives to the staff, to the doctors as well as to the States which implemented the programmes at a progressively faster pace.

The necessity for training the staff had also been emphasised and this had been accepted by the Government. Prof. Jagannadham said that there was need for an all-out approach for involving the universities in the mainstream of research and training. He hoped that the Family Planning Department would be in a position to consult some of the Universities and approach them for long-term research programmes. The urgent necessity for modifying the procedures and making them flexible enough to suit the exigencies of a programme like the family planning programme was emphasised. Prof. Jagannadham expressed the hope that the committee which had been appointed for evolving rules and procedures for sanctioning grants to voluntary organisations would take into view the criticisms mentioned in the three seminars and evolve procedures which would encourage voluntary organisations to play an effective role in this field. Prof. Jagannadham expressed the view that in all these three seminars there was emphasis on better education but he was doubtful whether education by itself could be instrumental for bringing about sociological change.

Prof. Jagannadham thanked the Ministry of Health and Family Planning for enabling the Institute to undertake these seminars and he also expressed his appreciation of the work done by the Institute staff for making the three seminars successful.

APPENDICES

APPENDIX I

DRAFT RESOLUTION ON FAMILY/WELFARE PLANNING POLICY FOR COMMENTS

1. The Constitution of India has declared in its Preamble that it aims at securing for all its citizens :

"JUSTICE, social, economic and political; LIBERTY of thought, expression, belief, faith and worship; EQUALITY of status and of opportunity; and to promote among them all FRATERNITY assuring the dignity of the individual and the unity of the Nation.

2. In the Directive Principles of State Policy, the Constitution provides that :

"The State shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall prevail and shall inform all the institutions of the national life" (Art. 38).

The State shall, in particular, direct its policy towards securing :

(*e*) that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;

(*f*) that childhood and youth are protected against exploitation and against moral and material abandonment". (Art. 39).

"The State shall make provision for securing just and humane conditions of work and for maternity relief". (Art. 42)

"The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties....." (Art. 47).

3. Guided by these Directive Principles, the Government of India and the State Governments have adopted planning for development as the main strategy for the fulfilment of the Constitutional obligations. The two fundamental approaches underlying the planning are : (1) to increase the production of goods and services and (2) to reduce the growth in the number of people demanding goods and services. The Government realises the limits of rapidly increasing the production of goods and services and therefore the Government simultaneously emphasises the importance of reducing the rate of increase in population.

In the First Year Plan, the Government realised that "the higher the rate of increase of population, the larger is likely to be the effort needed to raise *per capita* living standards". (p. 18) Many other constraints on the efforts to raise *per capita* living standards are accentuated by the rapid rise in population.

Government has since 1950 been aware of the need for planning and population control in the nation's developmental efforts. Realising the significance of the growth of population, the Government has so far been trying to bring down the birth rate from 45 to 25 per thousand.

Government also realises that the birth-rate remaining the same, and the death rate declining, the growth rate of population would assume alarming proportions in future. This realisation was reinforced by the decennial censuses of 1961 and 1971.

To bridge the gap between birth and death rates, the Government has adopted a number of approaches such as clinical extension education, cafeteria and camp campaign. There have been shifts from the clinical to the extension approach and from that to cafeteria approach. Recently, the campaign approach is becoming popular.

Realising the importance of family planning in the country, the Government created a separate Department of Family Planning in April, 1966. There is also the Central Family Planning Council, which coordinates the efforts of the Government at the Federal, State and Voluntary body levels. There are also other coordinating bodies at the Cabinet and Secretariat levels both at the Centre and in most of the States.

The Government of India is financing the Programme cent per cent although the bulk of the administration work is done at the State and District levels.

As regards the Family Planning Programmes, the Government's objectives are :—

1. to prepare the community to feel the need for family planning and use the services available for the purpose under the auspices of the governmental and non-governmental organisations;
2. to approach the people through various media and through several leaders to accept individually suitable methods of family planning without offending the religious values and moral susceptibilities;
3. to make available the services to the people on demand at their residences or nearest to their residences;
4. to make the services under the Family Planning Programme integral parts of medical and public health services and more particularly of mother and child health programmes.

Government notes with satisfaction that the programme has been catching up with the people both in the urban and in the rural areas. However, the experience during the decade 1960-70 during which intensive efforts have been made to spread the message of family planning and to make available the services under the family planning programme to as large a number of people as possible emphasises the gap between awareness and acceptance and consequently the Government feels it necessary to review the effectiveness of the efforts so far made. The experience of the last decade has brought to light the following points for re-consideration:—

1. The programme continues to be an activity of a department under Government auspices both at the Centre and in the States.
2. The programme has still not become a social movement.
3. Political and non-political leaders in different walks of life do not seem to be fully committed to the spread of the message of family planning in the country.
4. No political party has included family planning as part of its manifesto.
5. Religious and ethnic minorities do not seem to be enthusiastic about advocating or encouraging family planning practices among the members of their communities.
6. A direct correlation seems to exist between propensity for development and propensity for adopting family planning methods. As a consequence, it is found that development-prone States, Districts and communities seem to be more enthusiastic about accepting and following family planning methods than the less developed. As a result, Government is struck by the emergence of a paradoxical situation—the less developed have a great need to limit the size of the families, whereas, they are the most reluctant to choose and adopt appropriate methods for planning their families.

Government, therefore, feels that appropriate modifications in the policy and administration of the family planning have to be made to resolve the paradox and meet the other points mentioned above. One of the ways by which this could be done is to ascertain the factors adversely affecting adoption of family planning practices by the less developed areas or communities and from such knowledge, make suitable modifications in the methods of reaching the people for the purpose. Government would feel it necessary to adopt a differential approach to reach areas and communities in the light of the ascertained knowledge about differences in propensities towards the adoption of family planning programmes.

Government realises fully well that the activities of the Department have only a limited possibility of reaching the people without a fuller and more active participation of the community in the decision-making process and without the cooperation of organisations and leaders outside the Government.

With a view to achieve involvement of the people in the decision-making process, and to mobilise the cooperation of organisations and leaders outside the Government, the Government of India is keen to encourage the political parties and representative bodies at the National, State and Local levels to discuss thoroughly the pros and cons of family planning policy in their respective forums.

The Government of India is also eager to ascertain the views of the public about entrusting the administration of the family planning programme to an autonomous organisation at the Centre and in the States so that the Organisation may have greater freedom and initiative to experiment with several methods of approach in the people and getting them to accept the ideas of limiting the size of their families.

The Government of India is also keen to convert the family planning programme into a family welfare planning programme.

The Government of India would like to take an overall view of the needs and conditions of the families and provide social security services and social welfare services so that the fears arising out of the limitation of the size of the family would be mitigated by the services available under the various programmes.

The Government of India is also eager to encourage the voluntary organisations which, the Government feels, have a great role to play in mobilising the citizens of India to identify their individual aspirations with the national objectives. In the considered opinion of the Government,—the non-Governmental organisations are in an advantageous position and therefore, all efforts have to be made to liberalise and simplify the procedures in respect of grants-in-aid paid to the various non-governmental organisations under the various programmes so that while ensuring that proper safeguards have been maintained in spending public funds, the non-governmental organisations would be enabled to take advantage of the grant-in-aid available under the different programmes and make the national objectives part of the way of thinking and life of the people at large. It is also a policy of the Government to encourage the non-governmental organisations to play pioneering and stabilizing roles.

Further, the Government also appreciates that in the context of the family planning programme, it is particularly necessary to enable the people to understand and adopt small family norms. For this purpose, the Government of India and the State Governments are keen to lend support to all efforts and programmes for allaying the fears of the people arising out of their traditional values as regards having more than one son to maintain them in their old age. The Government is particularly anxious to achieve this object by encouraging the introduction of social insurance and social assistance programmes.

The Government is also desirous of making population education and family life education part of the curriculum of education in the Higher Secondary Schools and in Colleges. For achieving this uurpose, the Government wishes to ascertain the views of educationists expressed through their respective organisations.

The Government of India is also keen to reach the population in the far-flung areas of the country through more imaginative audio-visual means for spreading the philosophy and programmes for bringing down the growth rate of population in the country and thereafter, ensuring the flow of benefits of economic and social developments to the less fortunate sections of the population.

The Government of India is also keen to provide the necessary statutory basis for family welfare planning after studying the personal laws concerning the age of marriage, registration of marriage, etc. and for providing in an integrated way health and nutrition services for mothers and children as well as other social welfare and social security services.

The Government would like the urban and rural local authorities to assume a more extensive responsibility for spreading the message and providing the services under the family welfare planning programme.

Further, it is the policy of the Government to improve the organisation and administrative machinery for the formulation and implementation of the family welfare planning, policy and programmes. Besides constituting an autonomous organisation after a full consideration of its desirability, the staffing requirements of the organisation at different levels and the training needs for achieving the objectives of the organisation would be identified and pursued.

Government is of the view that for a social programme like planning the small family and providing family welfare services, the existing procedures under Government are not the most appropriate and therefore a revision of these procedures is under the active consideration of Government.

The Government appeal to the leaders and the people in both the organised and the not so organised sectors of Government, industry, transport, agriculture, commercial and academic to lend support to the spread of small family norms and to the adoption of family planning methods in the light of the integrated services that would be available to support and subserve the total welfare of the family throughout the length and breadth of the country.

APPENDIX II

FIRST SEMINAR

LIST OF PARTICIPANTS

1. Dr. Aurudh K. Jain
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   Assembly House
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5. Shri Ashish Bose
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6. Dr. Banidhar Baliar Singh
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7. Dr. B. K. Roy Burman
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8. Dr. (Mrs.) C. K. Luthra
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9. Shri D. Banerji
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10. Shri D. N. Chaudari
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11. Shri G. C. Verma
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    Directorate of Family Planning
    Delhi Administration
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12. Smt. Geeta Mukherjee
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    West Bengal Assembly
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13. Shri Jagannath Malik
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14. Prof. Jaswant G. Krishnayya
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15. Mrs. Kamala Rao
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16. Shri K. K. Dass
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17. Shri K. N. Rao
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18. Smt. Leela Damodara Menon
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19. Shri Lenni W. Kangas
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